August, 1958

Canadian Hospital

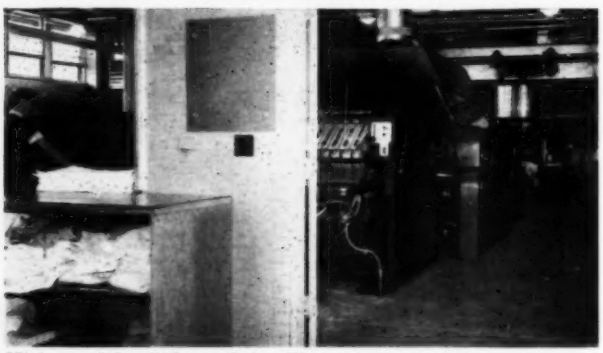
- *Mind over matter*
- *First eastern workshop*
- *Physiotherapists in Canada*
- *Nova Scotia hospital insurance plan*

Canadian Hospital Association

At Saint John General Hospital...

AUTOMATION IS KEY TO LAUNDRY MODERNIZATION

Three high-production Cascade Unloading Washers with Cascade Full-Automatic Controls, two of which are shown above, are easily handled by one man in addition to his other duties. Hoist-loaded Notrux Extractor (left foreground), Monex O. T. Extractor and Zone-Air Drying Tumblers further speed up work flow.



High-speed 8-roll Super-Sylon Flatwork ironer with Trumatic Automatic Folder enables a small crew to beautifully finish all linens for 685-bed Saint John Hospital. Linens are returned to service on a fast schedule.

These two push-button-operated Press Units round out Saint John Hospital laundry's complete service. Uniforms and other apparel are quickly finished on this modern Canadian equipment by just two operators.

Saint John General Hospital, New Brunswick, is the latest hospital to take advantage of the tremendous progress that has been made in the technological design of today's laundry equipment.

Washers, extractors and flatwork ironer with mechanical folder, all automatically controlled, save thousands of hours of costly labor. In addition, work is done better, faster and easier than ever before.

Automatically controlled laundry equipment strikes at the heart of the manpower problem because the laundry is one of the few places in a hospital where machines can do the work instead of people.

Find out today how quickly modern laundry equipment will reduce your operating costs, increase production, improve quality of work and boost employee morale. Call your nearby Canadian representative, or write direct for complete information.

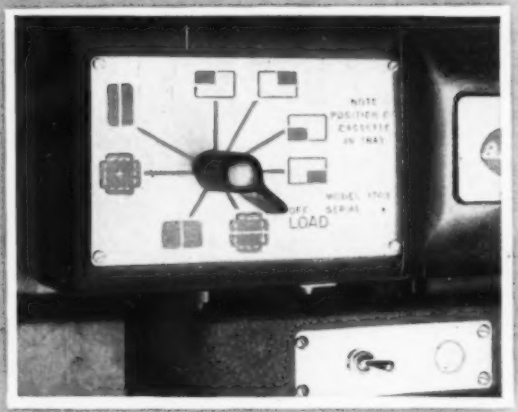
Canadian

The Canadian Laundry Machinery Company, Ltd.
47-93 Sterling Road Toronto 3, Ontario

WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver

you can fluoroscope any area up to 5" diameter at high light level. The intensified fluoroscopic image needs only 0.5 ma instead of the conventional 3 ma.

you can (by simply sliding the amplifying element back) fluoroscope at *conventional* light levels on a full-size 14"x14" screen for general exploration (eg. observing the whole esophagus during a barium swallow).



you can take spotfilms instantly (phototimed if you like) regardless of whether you're fluoroscoping on the full screen or through the amplifier . . . and get any of the patterns shown on this Program Selector.

you can do *cinefluorography* at will with this permanently mounted camera (optional). You control filming sequence by simultaneously watching the progress of the images on the Amplifilmer mirror.

83.3% less radiation

to patient...and to you during intensified fluoroscopy

shouldn't *you* have a

PICKER

*ampli*filmer?

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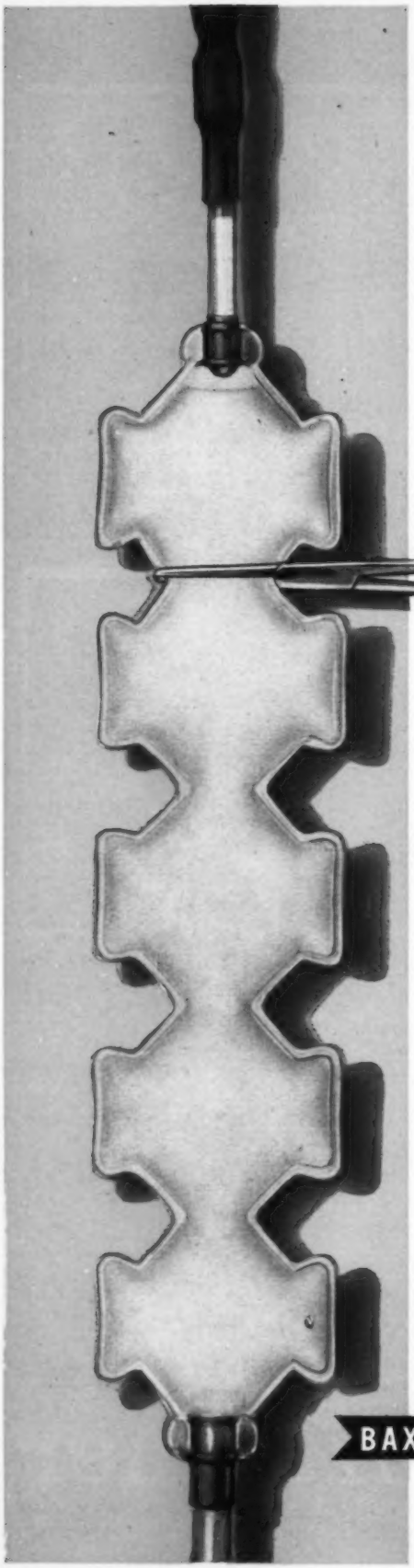
1074 Laurier Ave., West: Montreal P.Q.



New concept in PEDIATRIC *dosage control*

R36 PEDATROL*

New and radical in design, the segmented chamber of PEDATROL permits exact control of solution or blood administration, from 10 ml. to 50 ml., in increments of 10 ml.

Each compartment of the chamber holds precisely 10 ml. of fluid. By clamping off at any point between compartments you automatically set up the required dosage. Simple, efficient and accurate . . . without constant supervision. Once the hemostat is clamped, only the prescribed contents can be administered. Flashball® above top segment simplifies supplemental medication.

Make PEDATROL standard equipment in your Central Supply. Save nursing time . . . ease the work load . . . surely, safely, economically.

BAXTER LABORATORIES, INC. Alliston, Ont.

**Trademark of Baxter Laboratories, Inc.*

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Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
280 Bloor St. West, Toronto 5, Ont.

Contents

August, 1958, Volume 35, No. 8

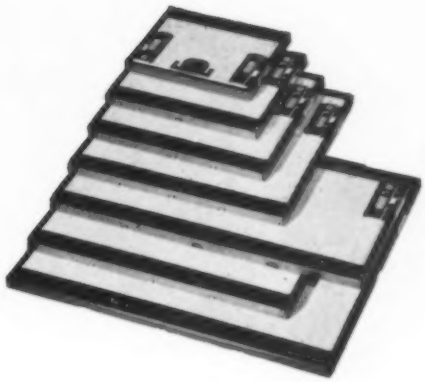
(For Subscription Rates see page 86)

Business Manager: Charles A. Edwards
Advertising Manager: Thomas L. Wells

Advertising Offices: 57 Bloor St. West, Toronto 5, Ont.

Truvision illuminator—everything you've wanted in a film viewer

Perfect for both wet and dry film viewing! Brilliant, uniform light, free of annoying lamp image. Housing of molded fibrous glass is absolutely corrosion-proof. And simply combining two or more units lets you enjoy an almost uninterrupted viewing panel. Toggle switch turns illuminator ON or OFF at a touch of the finger. See coupon for prices and details on alternate wall-mounted models.



Molded cassettes feature positive, built-to-last screen contact

Molded, one-piece rubber frame absorbs jolts, keeps front and back of cassette in *true alignment*. Built-in resilient glass fiber pad gently squeezes screens and film for uniform contact always. "Slide-easy" latches release at light finger pressure, yet resist accidental opening. Rubber seal, molded as integral part of cassette frame, prevents entry of light. Exclusive rubber hinge has been thoroughly proved in ½-million test flexings — *stayed bonded as firmly as at time of manufacture*. See coupon for prices.

CLIP THIS COUPON . . . Or, to obtain these and hundreds of other quality accessory and supply items, call your nearby General Electric x-ray office. You'll find it listed in the Yellow Pages of your phone book.

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GENERAL ELECTRIC X-RAY CORP., LTD.
MONTREAL 9, TORONTO 10, WINNIPEG 2, or VANCOUVER

YOUR NAME.....M.D.

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CHECK ITEMS REQUESTED:

Film: ☐ Ansco ☐ DuPont ☐ Ilford ☐ Kodak ☐ Screen ☐ No-Screen
(Available in boxes of 25, 75, 100)

☐ 5x7 ☐ 6½x8½ ☐ 8x10 ☐ 10x12 ☐ 11x14 ☐ 14x17

SUPERMIX LIQUIDS	DEVELOPER	REFRESHER	STAIN-LESS FIXER*	SPEED FIXER
26 oz. makes 1 gal.	$1.62	$1.64	$1.41	$1.63
12 or more, each	1.48	1.50	1.29	1.49
80 oz. makes 3 gal.	4.41			4.09
4 or more, each	4.02			3.73
1 gal. makes 5 gal.	5.83	5.88	4.87	5.34
4 or more, each	5.31	5.36	4.43	4.87

*Comes in 1 and 5 qt. only, to make 1 and 5 gal. of solution.

Spot Viewer.....$17.53
Mechanical Interval Timer.....$12.70
Send complete details on G-E pass boxes

VERI-O-PAKE:
250-lb. $140.35
100-lb. .....$ 59.40
25-lb. .....$ 16.06
6 or more 25-lb., each $ 14.61
5-lb., ...$ 4.81
6 or more 5-lb., each $ 3.52

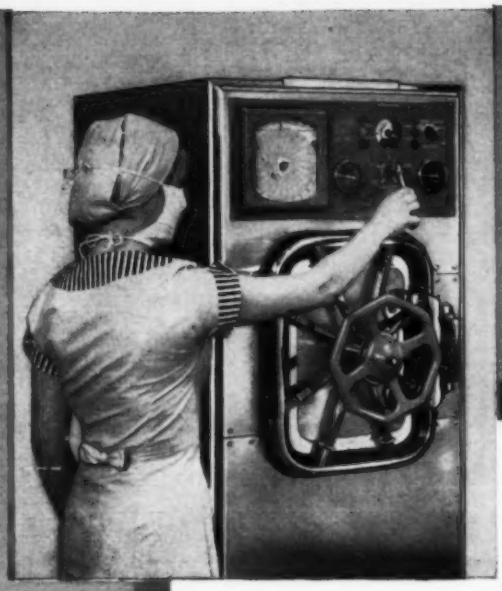
MOLDED CASSETTES:
5 x 7.....$14.30
6½ x 8½.....$16.85
7 x 17.....$24.00

5" x 7" Safelight.....$13.40

TRUVISION ILLUMINATORS:
1 to 3.....each $ 34.65
4 to 11.....each $ 33.65
12 to 24.....each $ 32.65
bank of 2.....$ 76.50
bank of 4.....$147.90
SEND INFORMATION on wall-mounted Truvision

8 x 10.....$18.35
10 x 12.....$20.40
11 x 14.....$23.75
14 x 17.....$25.75

Unless otherwise indicated, prices include duty, if any. Shipping charges, sales and use taxes must be added where applicable. Prices subject to change without notice.



Cyclomatic Control eliminates "remembering." "Unitized" Control Panel includes Indicating-Recording-Controlling Thermometer.

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high Speed

PRESSURE INSTRUMENT STERILIZER

12" x 16" x 24"

For All Instrument Sterilizing Procedures:

- 3-minute emergency
- Routine
- Pre-prepared wrapped instruments

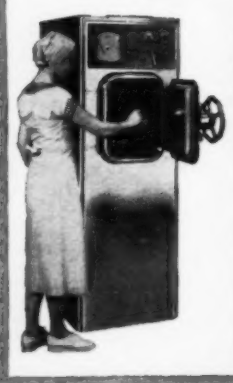
Major Advantages

SQUARE: 12" x 16" x 24" chamber provides 50% more useful space — takes three instrument trays, or basins and other utensils.

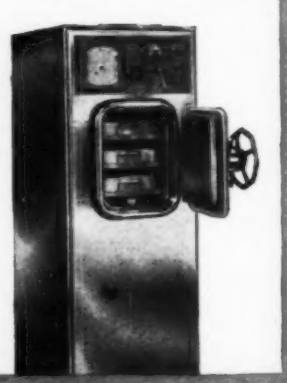
AUTOMATIC: Set-and-forget Cyclomatic Control ends doubts; assures thorough sterilization even under emergency stress.

FAST: Reaches 270° in 45 seconds; holds for 3 minutes; exhausts and dries in 60 seconds for complete emergency cycle of less than 5 minutes.

Write for illustrated bulletin SC-312



12" x 16" x 24" square chamber is large enough for basins and utensils.



Three full size instrument trays with "file drawer" suspension.

COOL • CLEAN • CONVENIENT • SURE

AMERICAN STERILIZER COMPANY OF CANADA LIMITED

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Notes About People

Director of Nursing at Trail-Tadanac

Rita Mary Ball has become the new director of nursing service at the Trail-Tadanac Hospital, Trail, B.C. Born in Vernon, B.C., Miss Ball came to Ontario in her high school days, and graduated from St. Michael's Hospital in Toronto. She holds a certificate in teaching and supervision from the University of Toronto and has spent several years on the staff of Mount Sinai Hospital. In 1940 she became director of nursing education at Misericordia Hospital, Edmonton, Alta., where she remained until 1957.

Miss Ball served as secretary and as president of the A.A.R.N. while she was in Edmonton. She also filled the rôles of chairman of the district committee of nursing education, and chairman of the Alberta committee of its film pool.

C.M.A. Elects Officers

The Canadian Medical Association, at its meeting in Halifax in June, 1958, elected the following officers: *President*—Dr. A. F. VanWart, Fredericton, N.B.; *Immediate past president*—Dr. M. A. R. Young, Lamont, Alta.; *President-elect*—H.R.H. The Duke of Edinburgh; *Deputy to the president-elect*—Dr. E. Kirk Lyon, Leamington, Ont.; *Chairman of the general council and the executive committee*—Dr. Norman H. Gosse, Halifax, N.S.; *Honorary treasurer*—Dr. G. W. Halpenny, Montreal, Que.

Medical Officer in Ottawa

E. H. Lossing, M.D., C.M., M.P.H., formerly chief of the Department of National Health and Welfare's epidemiology division, has been promoted to principal medical officer in charge of health insurance services.

Dr. Lossing was born in Norwich, Ontario, and received his medical degree from Queen's University in 1930. He held a rotating internship in Toronto's Western Hospital for the next year. Johns Hopkins University awarded him his Master of Public Health degree in 1954.

From 1931 to 1947, Dr. Lossing was in India, serving as civil surgeon with the Indian Medical Service and as superintendent of a medical school and hospital in Bengal. In 1952 he joined the Department of National Health and Welfare as assistant chief of the epidemiology division. He became chief two years later.

At Hamilton General

H. E. Appleyard, M.D., has been appointed as director of hospitals, to succeed Dr. J. B. Neilson, at the Hamilton General Hospitals, Hamilton, Ont.

After graduating with a medical degree from the University of Western Ontario, Dr. Appleyard did post-graduate work in England, where he became a member of the Royal College of Physicians of London, and later a fellow of the Royal College of Physicians and Surgeons of Canada.

He practised in Hamilton from 1936 until 1949, having four years of active service with the Canadian Army during the second world war. Dr. Appleyard then undertook two years' training in hospital administration from the School of Public Health and Administrative Medicine of Columbia University in New York, from which he received a degree of Master of Science in hospital administration. For the next three years he was assistant director of the University Hospitals of Cleveland, Ohio. He returned to Canada from there in 1953.

H. E. Appleyard, M.D.

Since then he has been superintendent of the Regina General Hospital, Regina, Sask., from where he has come to his new post.

Western Changes

Carl Christianson has been transferred from Clearwater Lake Sanatorium, Clearwater Lake, Man., to the Brandon Sanatorium, Brandon, Man. Mr. Christianson had been on the staff of Clearwater Lake for the past 12½ years, acting as business manager for the past few. Succeeding him at Clearwater Lake is Vic Olson.

In Brandon, Mr. Christianson succeeds Ray Gowing. Mr. Gowing, a graduate of the C.H.A.'s course in hospital organization and management, has taken up new duties at the Blood Indian Hospital in Cardston, Alberta.

Resigns Post on Medical Staff

After almost ten years as chief of obstetrics and gynaecology at Hamilton General Hospitals, Hamilton, Ontario, R. T. Weaver, M.D., has resigned the post. Dr. Weaver, as guest of honour at a Mount Hamilton Hospital reception, was presented with gold cuff links and tie pin by Elizabeth Ferguson, superintendent of nurses. Dr. Weaver, who is continuing in private practice, is succeeded by Dr. Fred L. Johnson as chief of service.

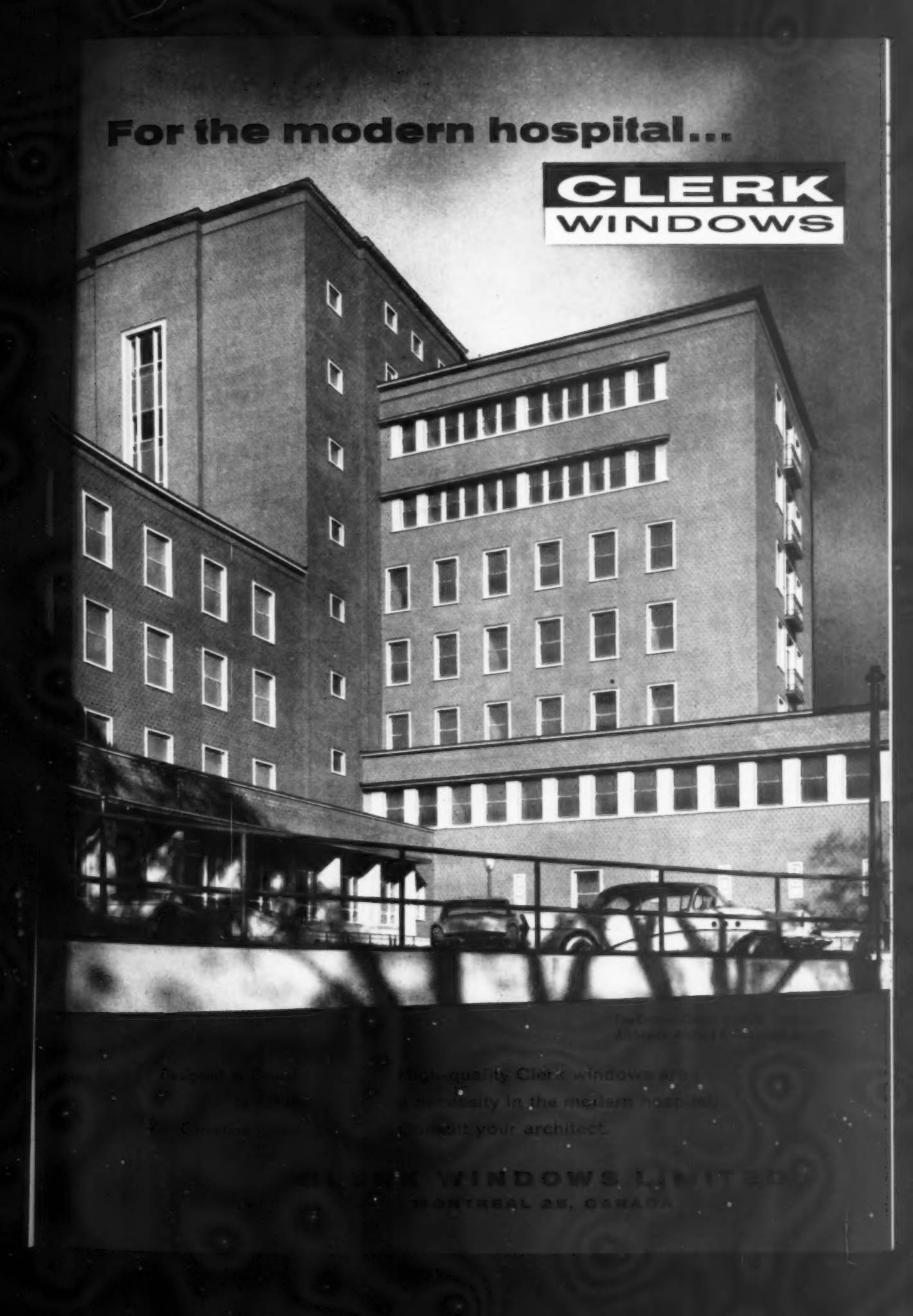
Joins St. Vincent Staff

Maureen Collins has been appointed as physiotherapist to the St. Vincent de Paul, Hospital, Brockville, Ontario. Miss Collins, formerly on the staff of the Hôtel Dieu de Montréal and St-Anne de Bellevue, in Montreal, Que., received her training in England where she had worked in physiotherapy before coming to Canada two and a half years ago.

Appointed to D.B.S.

John B. Davis has taken up his duties of chief of the Institutions Section of the Dominion Bureau of Statistics in Ottawa. Mr. Davis, who obtained a bachelor of com-

(concluded on page 20)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The ability to automatically match room temperatures and humidities to each of many specialized demands can make important contributions to any hospital's efficiency.

An optimum thermal environment may safeguard a patient's life. It helps shorten recovery periods, protects vital research processes, saves valuable staff time and reduces heating and cooling costs substantially!

A Johnson Pneumatic Temperature Control System with *individual room* control can bring these benefits to your hospital. Only a pneumatic control system can meet the diversified temperature and humidity requirements of the modern hospital and do it so simply, safely and economically.

Pneumatic control is far easier, less costly to operate, offers complete flexibility to meet every need. It's safe under all conditions—*even in the presence of explosive gases.* Upkeep is less—pneumatic control components outlast all other types. And only pneumatic controls can be used effectively with all types of heating and cooling systems.

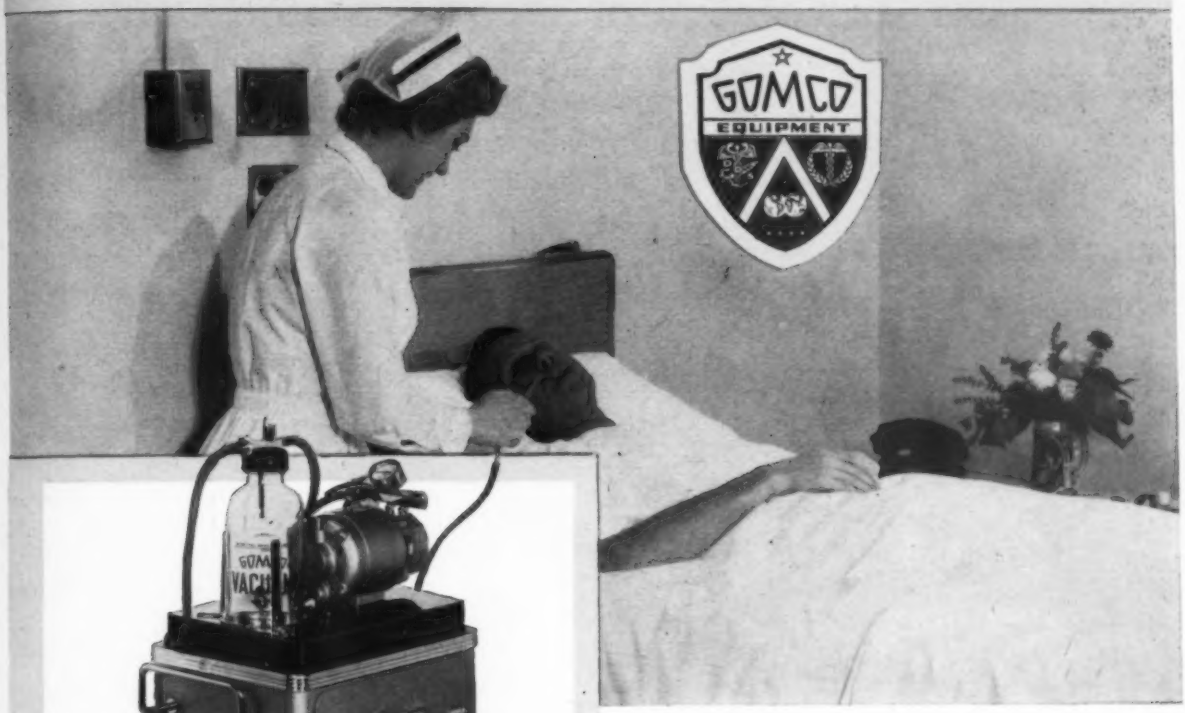
Let Johnson help improve the efficiency of your hospital by installing a control system that will assure you of an ideal thermal environment. A nearby Johnson engineer will welcome the opportunity to discuss with you, your consulting engineer or architect the control system best suited to your particular needs. Johnson Controls Ltd., Toronto 16, Ontario. Direct Branch Offices in Principal Cities across Canada.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

GROWING WITH CANADA SINCE 1912

Many Uses for This Compact GOMCO Aspirating Pump



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Like all Gomco equipment, the 789 is quality-built for years of trouble-free service. It is easy to clean, very simple to operate and requires a minimum of maintenance.

The lightweight Gomco No. 789 Aspirating Pump is saving valuable time and energy in thousands of hospitals and clinics from coast to coast. Weighing only 16 pounds, it is easily carried wherever the need arises.

The many important uses of the 789 include general post-operative work, removal of mucous from throats of newborn and for polio cases.

Accurate regulator valve and gauge provide precision control of suction from 0″ to 20″ of mercury. The exclusive, patented Gomco Safety Overflow Valve prevents pump damage by closing the suction system upon entry of moisture into the valve. Rubber-tired mobile stands are available if desired.

Ask your Gomco dealer to show you the many advantages of the 789 Aspirating Pump. He will be glad to demonstrate this and any of the other Gomco units in which you may be interested.

GOMCO SURGICAL MANUFACTURING CORP.

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Double protection

...double safety...

ready for instant use

The new A.C.M.I. Sterile Packaged Premium Catheter is double-protected by double packaging, for *assured* sterility. Even should the durable outer non-peelable package be torn or cut by unduly rough handling, the resilient inner peelable package still protects the sterile catheter from contamination.

Sterilization is achieved under rigidly controlled conditions; and is checked by thorough bacteriological testing before each lot is released. These catheters meet U.S.P. sterility standards and government specifications.

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Regular use assures excellent protection on surfaces against most pathogenic organisms, sanitizes all surfaces exceptionally well.

D.R.X. is designed to combat the ever present danger of cross-infection. D.R.X.'s positive action both as a cleaning agent and germicide provides greater protection where maximum antiseptic conditions are essential. This marked biocidal activity offers a much broader germicidal spectrum and is active over a wider pH range than most general germicides.

TESTS on D.R.X. indicate that it will destroy Staphylococcus Aureus, T.B. organisms, fungi, in a matter of minutes. D.R.X. is specifically recommended for use on acid-sensitive floors, such as terrazzo, marble, ceramic tile, terra cotta, as well as all other washable surfaces.

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Yes! Please forward immediately the FREE COPY of the "Golden Villain" article and other additional information on D.R.X. Germicidal Detergent for bacteriological cleaning.

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Sanitation for the Nation

BRANCHES ACROSS CANADA

MAIL THIS COUPON WITH YOUR LETTERHEAD TO-DAY

People

(concluded from page 14)

merce degree from Queen's University, Kingston, Ontario in 1949, is a 1957 graduate of the C.H.A.'s extension course in hospital organization and management. Since 1949 he has been in industrial accounting and has been assistant treasurer of the Ottawa Civic Hospital. For the past three years Mr. Davis has been the financial officer of the Department of Veterans' Affairs.

• E. M. Scott has resigned her post as superintendent of the Bingham Memorial Hospital, Matheson, Ontario.

C.N.A. Retirement Plan

A retirement plan, similar to that of the Canadian Medical Association, has been adopted by the Canadian Nurses' Association. Effective September 1, 1958, this plan provides the safety of an insured annuity plan, and guards against further inflation by a common stock pool. It has been arranged for a bank connected with the plan's arrangements, to accept regular contributions and transfer these funds to the plan.

Hospitals and other employers of C.N.A. members will be able to establish registered pension plans covering their nurses. One year of continuous service is required, but employees who are members of a registered employer-employee pension plan will be eligible to join as soon as they are employed by a participating person.

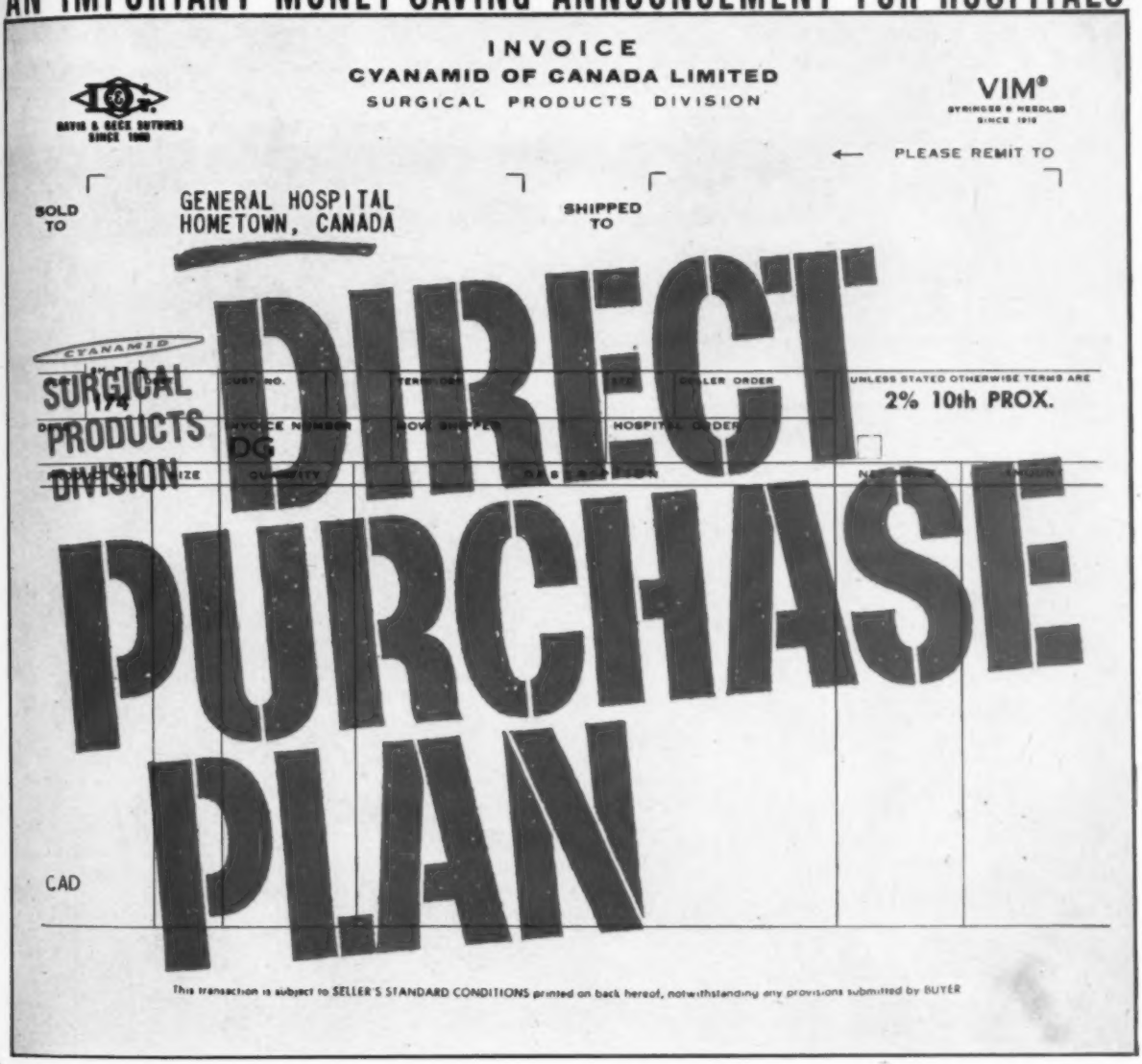
Basic contributions of employees will amount to five per cent of their earnings, but additional contributions are permissible. Allocation of basic and optional contributions between the insured annuity fund and the common stock fund may be in any proportion desired and may be changed once a year. Each year, employers will contribute five per cent of the employees' earnings, with a maximum of $1,500 per year for each employee. Employee contributions are fully deductible as far as income tax is concerned, and employer contributions are considered as deductible expense and are not added to the employee's income.

Upon retirement, the individual participating in the plan receives a fixed monthly income in proportion to what has been paid. In addition, the value of the member's common stock account will be transferred to the insured annuity fund over a five-year period prior to retirement and will be applied to purchase annuities.

Members of the C.N.A. who are self-employed, or who are employed where no employer contributions are available can join the registered savings plan portion of the scheme, and receive similar benefits through their own contributions as can participants in existing employer - employee pension plans who wish to supplement their retirement income and take advantage of the C.N.A. plan.

Employers wishing to participate in the plan may direct their inquiries to Miss Pearl Stiver, executive director, Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa, Ontario. The plan will be administered by the Canadian Nurses' Association's national headquarters in Ottawa, Ont.

AN IMPORTANT MONEY-SAVING ANNOUNCEMENT FOR HOSPITALS



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because Kraft dressings keep and keep, you can dress a tastier variety of salads!

Thanks to their high oil content Kraft dressings can be kept longer without spoiling. This means you can keep *several* on the go and vary your salad menu much more frequently . . . without a worry about costly deterioration. And this high oil content keeps salads fresh all day, eliminating waste. Serve salads dressed in the very best of taste . . . in Kraft dressings . . . the same fine dressings your customers like to use at home.

3 good reasons why Kraft dressings make good business sense:

1 the higher oil content protects your salads, keeps them fresh all day without discoloration . . . *there's never any waste or spoilage!*

2 rich, full-bodied dressings that won't break down or water-off in use . . . won't go to waste—*you use every ounce you buy everytime!*

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A "just right" touch of garlic and onion add to its hearty flavor. A great favorite with men.

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The most popular French dressing ever created . . . creamy thick, with the perfect touch of seasoning.

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Oil and vinegar, seasoned with unusual herbs and topped with a subtle, appetizing touch of fresh garlic.

CASINO FRENCH
A touch of sweetness . . . a smooth blend of tomatoes . . . a dash of fresh ground spices and seasonings.

MAYONNAISE
The perfect blend of finest salad oil, eggs and *extra* yolks, vinegar, seasoning and fresh lemon juice.

Phone your Kraft branch office for samples and a demonstration, or write for complete "cost-per-portion" details to: Institutional Sales Manager, Kraft Foods Limited, Box 6118, Montreal 2, Quebec.

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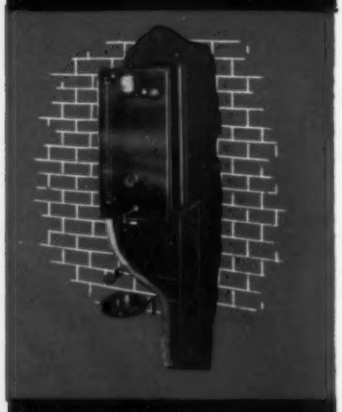

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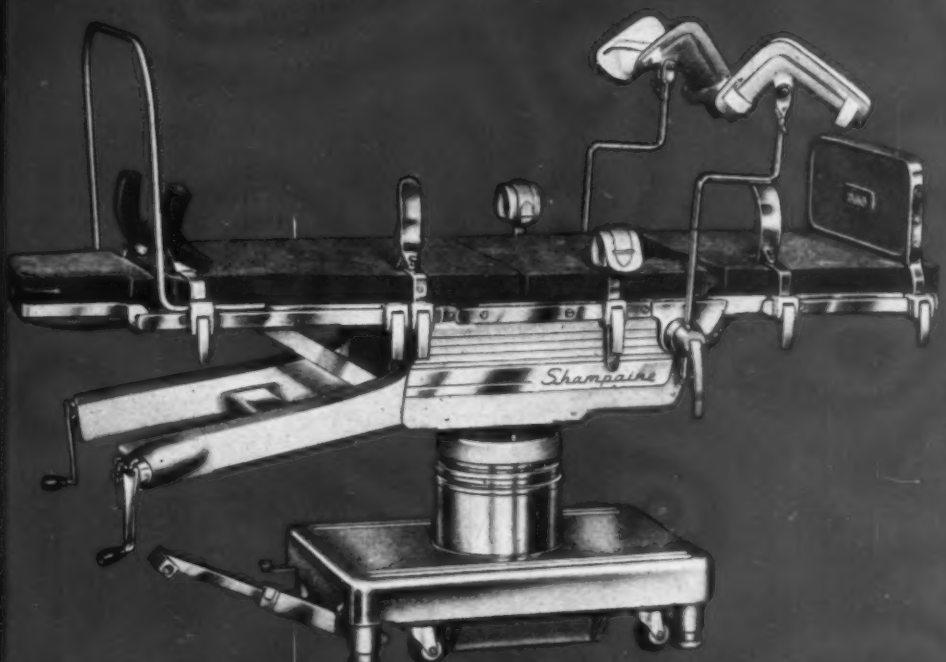

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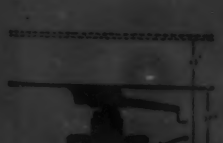

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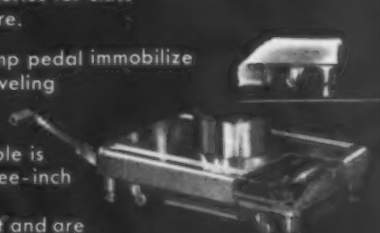

Coming up—O.H.A. Convention!

The Ontario Hospital Association will be holding its annual convention on October 27, 28 and 29 at the Royal York Hotel in Toronto. One of the highlights of this year's program is to be a session presented on the afternoon of Monday, the first day, which will be devoted solely to the Ontario Hospital Services Commission. Following two brief speeches by a hospital representative and a representative from the Commission (possibly on such topics as payments to hospitals for insured patients, and the hospital facilities and services available) there will be a panel discussion involving three Commission officials and three hospital administrators. This will afford the hospital people present ample opportunity to ask questions on any aspect of the hospital insurance plan.

At the symposium on Tuesday afternoon, October 28, three speakers will discuss the utilization of hospital services from the viewpoint of the O.H.S.C., the medical profession and the hospitals. Following this Dr. Virgil Slee, director, Commission on Professional and Hospital Activities, Ann Arbor, Michigan, will speak on "Evaluating Patient Care". His organization has developed a technique for evaluating professional activities, and this promises to be interesting and informative.

Also included in the program is "Personnel Administration", which will be handled by someone qualified in this field. Kenneth McFarland, educational consultant for General Motors, Topeka, Kansas, will discuss "Management is Everything" on Wednesday morning.

At the general session on Wednesday afternoon there will be a panel discussion of accreditation, with a representative from the new Canadian Commission on Hospital Accreditation to speak on this subject. As in previous years the various sections (of which there are nine in all) will be conducting their own meetings, with programs designed to cover their special areas.

Hospital Insurance Campaign

A vigorous enrolment campaign, extending from about July 19 to September 30, is being conducted by the Ontario Hospital Services Commission. The object is to sign up as many Ontario residents as possible for hospital insurance.

Member hospitals of the Ontario Hospital Association have been asked to assist. The hospitals may offer application forms (from attractive dispensers) to those who will be enrolling on a "pay-direct" basis, or they may attach to the mail going to residents in the area small stickers which bear the words: "Are you registered for Ontario Hospital Insurance? For details write: Ontario Hospital Services Commission, Toronto 7, Ont."

Apologia

St. Vincent's Hospital, Vancouver, B.C., was inadvertently omitted from the listing of accredited hospitals in Canada in the May issue of the *Journal*. We hope St. Vincent's will forgive us this error.

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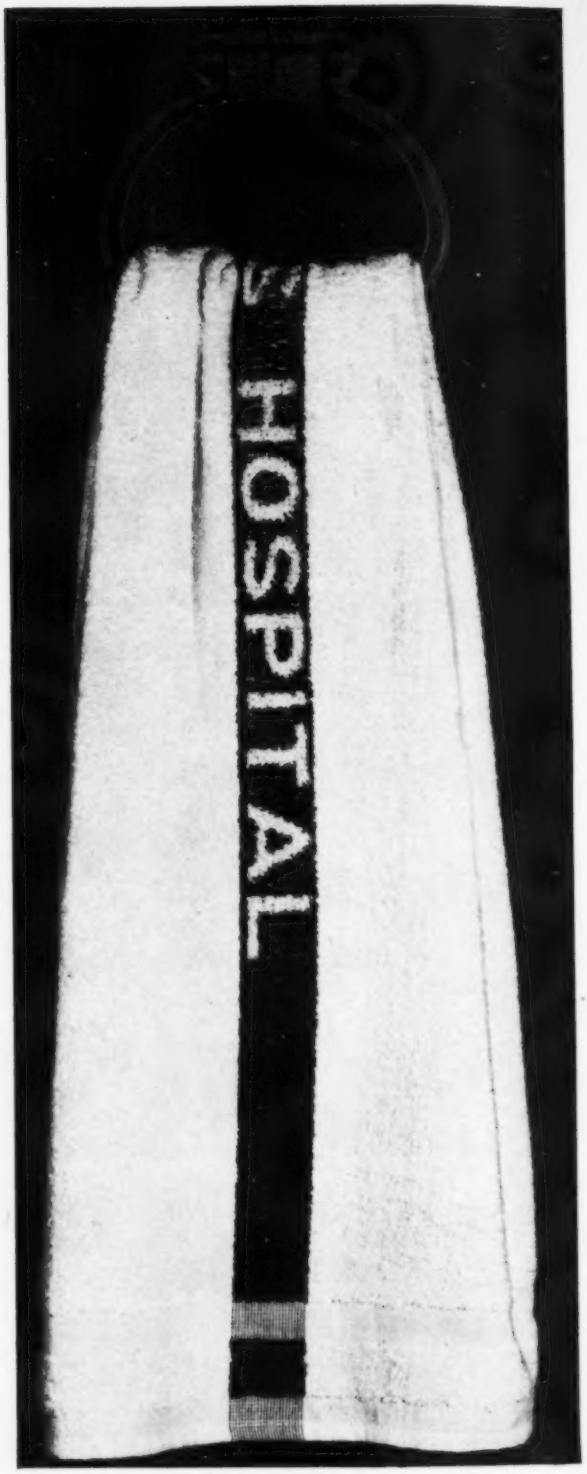

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The Canadian Hospital

Obiter Dicta

Institute on Hospital Insurance

DURING April 1958, the Nova Scotia Hospital Services Planning Commission held an institute on hospital insurance at Halifax. Each general hospital of the province was invited to send three representatives. The institute provided an excellent opportunity for board members, hospital administrators, departmental heads, and some members of medical staffs to learn, at first hand, details of the national hospital insurance program and its application in Nova Scotia. (It is expected that Nova Scotia's plan will become operative January, 1, 1959). The response to the commission's invitation was exceptionally fine—all general hospitals had at least one representative present and the great majority had three.

This institute was the first of its type in Canada. It consisted of formal papers, panel discussions, question and answer periods, and workshops. Speakers included several from the Department of National Health and Welfare, from the government of Nova Scotia, from the Nova Scotia Hospital Planning Commission, and also a number of hospital people. In all, some thirty papers were presented.

The Nova Scotia Hospital Planning Commission is making these papers available to all hospitals in Nova Scotia, but we believe that many of the subjects discussed will have a wide interest for hospitals throughout Canada. The papers contain a wealth of information dealing with many facets of hospital operation under the national hospital insurance program. In this issue we are publishing seven of the articles and more will follow subsequently. No topic holds more interest for hospital people today than national hospital insurance, and the Nova Scotia Planning Commission is to be commended for having sponsored the institute. We wish to thank the commission for making the papers available for publication in *the Canadian Hospital*.

The Law and You

We commend to all administrators and board members the article entitled, "How to avoid medico-legal problems", by Frederick Evis. This is in a series; the first part appeared in the July issue. The author sets out clearly authoritative views on questions to which many hospital administrators have sought answers. They are the kind of questions which come up, day by day, in the operation of any hospital. We believe that the administrator who takes the time to read this article carefully will be much better informed on his own legal responsibilities, as well as on those of his hospital in general. The whole article deserves close attention, but what Dr. Evis states about hospital bylaws, we hope will be read widely. The author says:

"Hospital bylaws which have been passed by the board of directors of a hospital in accordance with the authority delegated to them by the Public Hospitals Act and the regulations thereunder, which have been confirmed by a general meeting of the members of the hospital corporation and then approved by the lieutenant-governor-in-council, are just as much a part of the statute law of Ontario as is the Public Hospitals Act itself, and they should be respected as such. We often encounter a hospital where officials and staff take a very casual view of their hospital bylaws and apparently consider them a mere formality and of little consequence. In case of some misadventure in your hospital, a well drawn, approved set of bylaws can be a great comfort and protection to the board of directors and to the members of the professional staff involved—not to mention the lawyer who is to carry on your defence."

In recent years, many hospital people have shown an increasing interest in their bylaws—an interest in no small measure prompted by the program of hospital accreditation. Many have been stimulated to re-draft their bylaws in conformity with recom-

mendations of the Joint Commission and changes in government regulations. We believe this is as it should be and hope that Dr. Evis' comments will cause hospitals to have a greater appreciation of the bylaws' importance. A proper set of bylaws is the foundation on which sound hospital organization rests.

A Program of Our Own

THE all-Canadian program of hospital accreditation will start January 1, 1959. The objective of the project is still, of course, to help hospitals and professional staffs in their efforts to improve patient care. Thus, it is basically an educational movement. If a hospital has 25 beds or more, is listed as a hospital in the *Canadian Hospital Directory*, is licensed by the proper provincial authority, and has been in operation for 12 months, it can then apply for accreditation. At the present time, only some 40 per cent of the eligible Canadian hospitals are accredited. Under the all-Canadian program, it is hoped that the accreditation rate of the smaller hospitals, now the lowest, will improve. Patient care is just as important in the small as in the large institutions; and the accreditation standards are applicable to both.

After five years of excellent co-operation with the Joint Commission on Accreditation of Hospitals, the long anticipated commencement of the all-Canadian program is now in sight. In inaugurating their own program, the Canadian Commission accepts, without change, the basic principles of the Joint Commission. In methods of procedure only will changes be made. These will be changes which will aid interpretation of standards and the re-statement of certain requirements in more specific terms, to give recognition to the best in Canadian hospitals. There is a wide scope in which the Canadian Commission can adapt its program to the needs of a bilingual country, in keeping with the best in Canadian hospital traditions. There is also anticipated, the advantage of helping to establish a common hospital language on a national basis, so that when we use the same words, we will all mean the same thing, thus improving communication.

We should not forget the debt we owe to the American College of Surgeons, which for some 35 years conducted a program of hospital standardization. Nor should we forget the service done by the Joint Commission on Accreditation of Hospitals during the past five years. The Canadian Commission, in setting up its own accreditation program, must not lose sight of the leadership given, and the invaluable contributions made by our American friends during the past 40 years. It will be the duty of the Canadian Commission to look for continued co-operation for the improvement of patient care in both countries. Much work remains to be done to ensure that the accreditation movement in Canada is firmly established. It is a program that all hospitals, large and small, should support actively.

Un Programme qui nous est Propre

LE programme entièrement canadien d'accréditation des hôpitaux entrera en vigueur le ler janvier 1959. L'objectif du projet est toujours, bien entendu, d'adider les hôpitaux et corps médicaux dans les efforts qu'ils font pour améliorer les soins aux malades. Il s'agit donc, fondamentalement, d'un mouvement éducationnel. Si un hôpital a vingt cinq lits ou plus, s'il figure en qualité d'hôpital dans l'*Annuaire des Hôpitaux du Canada*, s'il est patenté par l'autorité provinciale compétente, et s'il a fonctioné pendant 12 mois, il peut demander l'accréditation. Actuellement, seulement 40 pour cent environ des hôpitaux canadiens remplissant ces conditions sont accrédités. Avec l'application du programme entièrement canadien, on espère que le pourcentage d'accréditation des plus petits hôpitaux, qui est actuellement le plus faible, s'améliorera. Le soin des malades est tout aussi important dans les petits établissements que dans les grands; et les normes d'accréditation sont applicables aux uns comme aux autres.

Après cinq ans d'excellente collaboration avec la Commission Mixte d'Accréditation des Hôpitaux, la mise à exécution du programme entièrement canadien, depuis longtemps attendue, est maintenant en vue. En inaugurant son propre programme, la Commission Canadienne accepte sans changements les principes fondamentaux de la Commission Mixte. Seules les méthodes de procédure seront sujettes à modifications. Ces modifications auront pour effet de faciliter l'interprétation des normes et comprendront également un exposé de certaines conditions rédigé en termes plus spécifiques pour tenir compte et entériner les meilleures des règles appliquées dans les hôpitaux canadiens. De vastes possibilités s'offrent à la Commission Canadienne en ce qui concerne l'adaptation de son programme aux nécessités d'un pays bilingue, tout en conservant les traditions hospitalières canadiennes. Ce que l'on prévoit aussi, c'est l'avantage d'aider à l'établissement d'une terminologie hospitalière commune sur une base nationale, afin que, pour nous tous, les mêmes mots signifient les mêmes choses améliorant ainsi nos communications. Il ne faut pas oublier notre dette envers le Collège Américain des Chirurgiens qui, pendant quelque trente cinq ans a dirigé un programme de normalization des hôpitaux. Il ne faut pas non plus que nous oubliions le travail fait par la Commission Mixte d'Accréditation des Hôpitaux au cours des cinq dernières années. La Commission Canadienne, en établissant son propre programme d'accréditation, ne doit pas perdre de vue ceux qui lui ont montré la voie, non plus que l'inapréciable contribution fournie par nos amis américains au cours des quarante dernières années. Il est du devoir de la Commission Canadienne d'assurer la continuité de la collaboration pour l'amélioration des soins aux malades dans l'un et l'autre pays. Il reste beaucoup à faire pour asseoir fermement le mouvement d'accréditation au Canada. C'est un programme que tous les hôpitaux, grands et petits, devraient activement appuyer.

Summer Reading

JULY and August are traditionally holiday months when most staff members take their annual vacation. During this time those who remain on the job have to carry the extra load of pinch-hitting. These two months are, therefore, not the best for most of us, for keeping abreast of current literature. But in the opinion of your editor, at least, there are several excellent articles in our July and August issues. If you are going on vacation, we hope you will take these issues with you; if you are returning to work, we hope you will, nonetheless, find time to look through them carefully.

A Report on

Physiotherapists in Canada

distribution
and work in
general hospitals
special hospitals
treatment centres

Helen M. Gault
M.C.S.P., M.C.P.A.
Montreal, Que.

Part 1

IN CANADA, physiotherapy was not given the opportunity to prove its worth until the conclusion of the second world war. Doctors, returning from overseas, demanded the same services for their civilian patients as had been accorded personnel in the armed forces. At that time few hospitals had physiotherapy departments and those that had were in large centres. This new demand, coupled with the extensive immigration program of the Canadian government, resulted in the employment of many foreign-trained therapists without, at first, much enquiry regarding their qualifications. Then several institutions in Canada sent members of their nursing or orderly staff away for short courses of a few months to enable them to establish their own departments.

The Canadian Physiotherapy Association, which received a dominion charter in 1920, was alive to the fact that the physiotherapy expected by doctors returning from the forces was of a higher calibre than that which began to make its appearance through the indiscriminate employment of foreign-trained or self-taught technicians. It was felt that something had to be done to assure the high standards of the profession which the association has worked indefatigably to maintain. At the time of writing this report six provinces have legislation which prohibits unlicensed practitioners in hospitals, treatment centres, or private practices. The standard set by each of these six provinces through the work and co-operation of physiotherapists, doctors and provincial governments, corresponds in each case to that laid down by the association for membership. Moreover, the provincial Acts require that applicants for licences be acceptable for membership in the association. Therefore the standards have already been set by provincial Acts for 63.5 per cent of the total population, and efforts are being made to assure proper professional care in the remaining provinces.

As yet, the association has set no standards which would govern, according to size of hospital, staff requirements, space necessary, or equipment required in order that the therapists may do justice to their patients and to their profession.

The School of Physiotherapy at McGill University is often asked for advice by those concerned with the planning of new departments. Therapists in existing departments are also showing an increasing desire for information whereby they can compare their departments with working conditions elsewhere in Canada.

The absence of set standards makes necessary an alternative basis for guidance in answering these enquiries. This alternative is an analysis of existing departments of physiotherapy to discover their relative strength and weakness, and data on the features that have proved to be practicable in given circumstances. The author believes that the number of enquiries hitherto received has justified such a study and the publication of a report on the findings.

Since the second world war, 114 new departments have opened in existing and new hospitals, and many more are under construction. We know that 800 physiotherapists are on the active list of the Canadian Physiotherapy Association. They are employed in general hospitals, hospitals for special conditions, rehabilitation centres, cerebral palsy centres, special schools, and by the Canadian Arthritis and Rheumatism Society in mobile units, private clinics and private practices. Of the above group 588 are practising in 173 general and special hospitals and centres which are known to the Dominion Bureau of Statistics and/or the Canadian Physiotherapy Association.

The purpose of this paper is to:

1. Give information on the numbers, qualification, and distribution of therapists;
2. Show the distribution of therapists and the services rendered in all provinces.
3. Give an account of the auxiliary assistants and secretarial staff;
4. Provide information regarding the cost of maintaining a department;
5. Indicate the average space

Mrs. Gault, who is assistant professor at McGill University's School of Physical and Occupational Therapy, acknowledges the kind assistance of the Canadian Physiotherapy Association, the Dominion Bureau of Statistics, and Dr. Rae Chittick and Mrs. G. T. Hurd of the McGill School for Graduate Nurses.

and apparatus required for hospitals and centres in proportion to the size of the institution as received in the study.

Definitions

A qualified physiotherapist is one who has attained such qualifications as are required by the licensing laws of the province in which the therapist practises or by the standards of the Canadian Physiotherapy Association in those provinces where no licensing laws are in force. Unless noted otherwise, the term physiotherapist is used to denote a qualified physiotherapist.

An unqualified assistant may be anyone who, through insufficient training, is not acceptable for licensing and may therefore work only under supervision of a qualified therapist. She may be a person who has received no training at all and is solely occupied with helping patients undress and dress, preparing baths or apparatus and being responsible for some of the housekeeping in the department.

A remedial gymnast is a man trained to give exercises in classes or give individual exercises which are usually under the direction of the physiotherapist.

Method

A list of names and addresses of hospitals with physiotherapy departments was compiled from information received from the Dominion Bureau of Statistics, the Canadian Physiotherapy Association and professional colleagues.

A comprehensive questionnaire was drawn up to obtain the following information: (a) size, ownership and services supplied by hospitals and centres; (b) physiotherapists, medical directors of physiotherapy departments, auxiliary personnel and clerical staff; (c) physical plant and cost of operation; (d) apparatus used; (e) in-service education and teaching responsibilities of therapists.

The questionnaire was tested by sending it to three large hospitals offering a variety of services to the public. It was mailed with a covering letter and a self-addressed envelope to 203 hospitals. One hundred and sixteen were selected from the Dominion Bureau of Statistics list of 153 (27 were omitted because their departments were not known by the author to be staffed by qualified therapists and ten were omitted inadvertently). The files of the association and colleagues yielded a further 87. Of the total of 203, 180 returns were submitted. Seven of these are concerned with private practices or the Canadian Arthritis and Rheumatism Society and are omitted from this report, for their number is insufficient to represent either group and, as these groups represent a considerable percentage of the physiotherapists across the country, a special survey should be made for each.

There was a discrepancy between the total number of beds shown in this survey of 1957 and the Dominion Bureau of Statistics list of the previous year. In all probability the bed capacity of the hospitals has increased in the interim between the two surveys, so the larger totals of 1957 have been used.

The following report, therefore, is based upon a return of 85.2 per cent of all known hospitals and centres with accredited departments, excluding the Canadian Arthritis and Rheumatism Society and private practices.

Table 1

Questionnaires

Province	No. Distributed	No. Returned
Nfld.	3	3
P.E.I.	2	1
N.S.	7	7
N.B.	7	7
Que.	30	30
Ont.	81	67
Man.	7	7
Sask.	16	14
Alta.	21	18
B.C.	29	26
Total	**203**	**108**

Table 1 shows the percentage of returns for each province and it will be noted that complete reports were received from five provinces. *Table 2* shows the classification of all hospitals over 50 beds according to ownership and the number and percentage of hospitals over 50 beds reporting physiotherapy departments. It will be noted that hospitals supported by voluntary subscription, municipalities, and the federal government have a higher percentage of departments of physiotherapy than those supported by provincial governments, religious orders and those in the "other" category.

Numbers and Distribution of Physiotherapists

Table 3 shows the distribution of physiotherapists, in hospitals reporting physiotherapy departments, by province, number and percentage of therapists, country of training, and increase in the last three years. Both full and part-time therapists have been included under one total. Part-time practitioners are too few to warrant the separation of the two. Only 50 per cent of the total qualified therapists have been trained in Canada, where four universities now accept students and two of these take men. Of the four, three are English-speaking and one is French-speaking.

Table 4 gives, by provinces, the ratio of physiotherapy-serviced beds to population. This subdivision is required because of the range of population in the provinces. Except in the province of Quebec, the more populated provinces have a higher ratio of serviced beds to population.

Table 2

Hospital Ownership	Classification of hospitals over 50 beds according to ownership		Hospitals over 50 beds reporting physiotherapy departments	
	Number	Percent	Number	Percent
Lay Board	184	32.5	56	37.0
Provincial	73	12.9	13	8.6
Municipal	74	13.1	29	19.2
Religious Order	177	31.3	32	21.2
D.V.A. and Armed Forces	29	5.1	17	11.3
Other*	29	5.1	4	2.7
Total	566	100.0	151	100.0

*"Other" hospitals owned by Indian Health Services, industries, Can. Paraplegic Association, et cetera.

Table 3

Province	Hospitals		Therapists		Country of training				Increase 1954-57
	Number Reporting	Percent of total hospitals reporting	No. Therapists	Percent of total therapists	Canada	Britain	USA	Europe	
Alta.	16	9.2	68	11.6	33	25	1	10	27
B.C.	25	14.5	90	15.2	17	50	3	18	8
Man.	7	4.0	26	4.5	11	7	1	7	5
N.B.	7	4.0	14	2.4	8	6	0	0	6
Nfld.	3	1.7	8	1.4	2	4	2	0	2
N.S.	7	4.0	22	3.7	15	6	0	1	9
Ont.	64	37.2	210	35.7	132	55	1	22	56
P.E.I.	1	.6	2	.3	2	0	0	0	0
Que.	30	17.3	115	19.6	64	40	0	11	31
Sask.	13	7.5	33	5.6	13	15	3	5	0
Canada	173	100.0	588	100.0	297	208	11	74	144

Table 4

Ratio of Total Number of Beds in all Hospitals with Physiotherapy Departments to Total Population by Province 1957

Province	Gen. Hosp.	Spec. Hosp.
Alta.	335	1003
B.C.	281	337
Man.	467	520
N.B.	741	1109
Nfld.	717	902
N.S.	726	1103
Ont.	318	653
PEI.		3009
Que.	714	1024
Sask.	248	800
Canada	406	721

Table 5 shows the ratio of numbers of physiotherapists to total beds in general and special hospitals with physiotherapy departments.

Table 5

Province	Beds per Therapist	
	Gen.	Spec.
Alta.	101	159
B.C.	136	172
Man.	148	118
N.B.	88	554
Nfld.	87	460
N.S.	154	39
Ont.	110	119
P.E.I.		15
Que.	88	156
Sask.	132	1100
Canada	102	133

Types of Service and Work Done

Table 6 shows in detail, for each province, services in general hospitals, distribution of therapists, and amount of work done. The few departments failing to submit complete returns have been omitted. Cause of failure may have been lack of records showing number of patients and number of treatments per patient per week, or lack of explicit wording in the question. The questionnaire column headed "Number of treatments per week" meant number of patient contacts, irrespective of number of

Table 6

Number of Physiotherapists, Beds Serviced, Patients Seen and Treatments Given and Ratios to Beds, Patients and Treatments in General Hospitals by Province 1957

Province	General Hospitals								
	No. of possible reports	No. of complete reports	No. of therapists	No. of beds	No. of beds per therapist	No. of patients per week	No. of patients per therapist per week	No. of treatments per week	No. of treatments per therapist per week
Alta.	9	8	41	3300	78	939	23	4042	99
B.C.	18	15	42	4841	115	2354	56	5061	121
Man.	4	4	12	1819	151	625	52	1086	91
Nfld.	2	1	6	446	74	80	13	425	71
N.B.	4	4	10	745	75	215	21	655	65
N.S.	3	2	5	815	163	100	20	537	107
Ont.	40	39	123	16808	137	2756	22	11002	89
P.E.I.	—	—	—	—	—	—	—	—	—
Que.	18	17	76	6442	87	2628	35	6295	83
Sask.	11	10	26	3508	134	1726	66	2878	111
Canada	109	100	341	38727	114	11423	33	31981	94

Table 7

Table of Distribution of Special Hospitals with In-patient and Out-patient Physiotherapy Treatments, by Province, 1957

Services	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
Rehabilitation		1			2	3			1	1
D.V.A.			1	1	3	3	1		1	3
Armed Forces			2			2				
Geriatric			1		1	6	1		1	
Psychiatric					1			1		1
Tuberculosis	1				2	1			1	1
Cerebral Palsy			1							
Communicable Disease					1					

physiotherapy techniques used during any one treatment. The heading "Number of patients" meant the number of names on the department file for that week. In a few cases monthly returns were obviously submitted and have been adjusted to a weekly basis. Where checking proved a large load to be due to the presence of auxiliary staff, working under the supervision of a qualified therapist, the numbers were not adjusted and this accounts for some higher ratios. Most hospitals in this list have both in-patient and out-patient clinics.

In the general hospitals the average number of treatments given during a week by a therapist, or supervised by a therapist is 94, or 17 per day for five and a half days. This represents a case load of approximately 33 patients per therapist. The ratio of patients to number of treatments received by each is 2.8, but this figure covers not only patients on daily, or alternate daily, treatment but also those attending only once for instruction, either prior to operation or to discharge from hospital.

The column of ratios between therapists and patients indicates abnormally high figures for general hospitals in Quebec, British Columbia, Saskatchewan and Manitoba. This can be explained in either of two ways; either the general hospitals are giving large exercise classes in the gymnasium or are using auxiliary personnel to give treatments, because Quebec reports four unqualified assistants, six voluntary workers and one remedial gymnast; British Columbia reports nine unqualified assistants; Saskatchewan reports eight unqualified assistants and one remedial gymnast; and Manitoba three remedial gymnasts. As the survey made no attempt to analyze actual treatments done in the hospitals, or duties of unqualified assistants and remedial gymnasts, no conclusions can be drawn at this time but a future survey for this purpose may elicit this information from all hospitals.

Table 7 shows distribution of special hospitals and treatment centres, Department of Veterans Affairs and armed forces' hospitals across the country. Only five provinces reported rehabilitation centres and services in hospitals for tuberculosis, only four provinces claimed departments concerned solely with geriatric, chronically ill or convalescent patients.

Table 8 shows distribution of therapists and amount of work done in special, D.V.A. and armed forces' hospitals. They are listed only as a Canadian total, due to their small number, but figures for each province are available to anyone wishing them.

The D.V.A. and armed forces show a high ratio of patients and of treatments per therapist. The use of auxiliary personnel, or else of large exercise classes, may again explain this high ratio.

Table 9 shows the number of physiotherapy treatments given and number treated in rehabilitation centres and cerebral palsy centres which report treatment only of outpatients. British Columbia reports a low ratio of 1.110 therapists to patients, but their staff is augmented by eight unqualified assistants and six remedial gymnasts.

Auxiliary Personnel

The total number of reports received shows that there are

Table 8

Special Hospitals and Centres

Services	No. of possible reports	No. of reports completed	No. of therapists	No. of beds per therapist	No. of beds per therapist	No. of patients per week	No. of patients per therapist per week	No. of treatments per week	No. of treatments per therapist per week
Rehabilitation	9	8	41	807	20	867	21	5077	124
D.V.A.	13	13	58	9061	156	2047	35	10615	181
Armed Forces	5	4	9	386	43	270	30	1400	155
Geriatric	11	9	24	2545	106	488	20	2019	88
Psychiatric	4	3	7	5441	777	100	14	595	85
Tuberculosis	6	6	8	2034	254	198	28	873	109
Cerebral Palsy	2	1	7	20	3	70	10	375	54
Communicable Diseases	1	1	2	140	70	20	10	110	55

Note. Geriatric includes the chronically ill and the convalescent patient.
Cerebral palsy includes Schools for Crippled Children and children's rehabilitation centres.

66 hospitals, or 41.2 per cent with 0-199 beds; 51 hospitals, or 31.9 per cent, with 200-499 beds; and 43, or 26.9 per cent with over 500 beds. Of this total of 160 hospitals, 146 have sent in full reports from which the following figures have been drawn.

Table 10 shows the number and percentages of auxiliary personnel, including remedial gymnasts, unqualified assistants, and clerical staff in small, medium, and large hospitals.

Hospitals of 500 beds and over employed 51.3 per cent of all physiotherapists, who saw 58.5 per cent of all patients and gave 59.5 per cent of the total treatments. They also employed 73.3 per cent of all remedial gymnasts, 46.3 per cent of unqualified workers and 54.5 per cent of full time secretaries. These larger hospitals tended to have a high proportion of remedial gymnasts and unqualified assistants, but secretarial assistance was lower than would be expected. Five large general hospitals, each employing three or more therapists, have no secretarial assistance.

The small hospitals accomplish proportionately less work than the medium sized hospitals, although only 2 per cent behind in the number of therapists (Table 10), but only ten of these small hospitals in the general list report unqualified or remedial assistants.

Table 9

In Centres with Out-Patients Only, 1957

Services	No. of Treatment Centres	No. of Therapists	No. of Patients per week	No. of Patients per therapist per week	No. of Treatments per week	No. of Treatments per therapist per week
New Brunswick						
Cerebral Palsy	2	2	52	26	180	90
Quebec						
Rehabilitation	2	9	380	42	668	74
Ontario						
Cerebral Palsy	4	11	222	20	616	56
Saskatchewan						
Cerebral Palsy	1	5	50	10	250	50
Alberta						
Cerebral Palsy	2	3	118	39	185	62
Rehabilitation	1	16	500	31	1800	84
British Columbia						
Rehabilitation	1	20	2200	110	10363	518

Cost of a Treatment

The hospitals appear to have difficulty in answering the question asking for the cost per patient for a treatment. Perhaps not many hospitals keep separate accounts for the physiotherapy departments or else some had reason not to divulge them. Many replies gave the cost to the patient for a treatment. Such answers have been discarded. Figures from the remaining replies have been averaged in *Table 11*. These show a remarkable similarity, one to another, apart from the higher running cost of smaller hospitals than of medium and large institutions. It would appear that any hospital with a case load sufficient to justify a full-time therapist can, by instituting a scale of fees at an average of $2.25 per treatment, provide the patients with qualified

(concluded on page 80)

Table 10

Numbers and Percentages of Hospitals, Physiotherapists, Patients Seen and Treatments Given and Auxiliary Personnel and Staff in Hospitals by Size Submitting Complete Reports 1957

Number of beds	Hospitals with Physiotherapy Departments		Therapists		Treatments		Patients	
	No.	Percent	No.	Percent	No. per week	Percent	No. per week	Percent
1-199	56	38.3	112	23.2	9761	19.1	2722	17.9
200-499	49	36.6	123	25.5	13529	26.4	3601	23.6
500 and over	41	28.1	248	51.3	27874	54.5	8909	58.5
Total	146	100.0	483	100.0	51164	100.0	15232	100.0

Remedial Gymnasts		Unqualified Assistants		Full-Time Clerical Staff		Part-Time Clerical Staff	
No.	Percent	No.	Percent	No.	Percent	No.	Percent
6	9.6	14	17.5	10	21.7	15	37.5
11	17.1	29	36.2	11	23.9	15	37.5
47	73.3	37	46.3	15	54.4	10	25.0
64	100.0	80	100.0	46	100.0	40	100.0

Nova Scotian Institute

seven facets of a provincial plan for hospital insurance

Highlights

K. C. Charron, M.D.

THE hospital insurance and diagnostic services program in Canada has been developed to provide a two-pronged approach to hospital care and diagnostic services. On the one hand, it provides a system of prepayment to cover the cost of care in hospital; and on the other, it includes similar arrangements to cover the costs of diagnostic services. In order to participate, a province covenants to provide in-patient services which must include both aspects of the program. In-patient services, as will be described more fully later, must include diagnostic services.

In addition to the combined hospital and diagnostic services, which are both integral parts of in-patient services, a province may choose any of the in-patient benefits and extend the service to out-patients. In recognition of the probability of provinces' using certain facilities in addition to hospitals, in connection with out-patient services, the definition of "hospital" contained in the federal Act, has been designed to include these facilities.

The federal Act and Regulations authorize the dominion government to contribute to the cost of provincial programs for hospital insurance and diagnostic services. In addition, the offer also includes technical assistance, which will be provided in two ways; (a) by specialist staff in the Department of National Health and Welfare to act as consultants, and (b) through the national health grants program for technical advisory services, research, and training.

I would like to emphasize that these proposals are much more than fiscal assistance. Insured persons will not be indemnified for the cost of hospital care, but will be provided with a service made available to them on a prepaid basis. The essential difference between an indemnity program and this service-centred approach is the interest and concern in the latter with quality of care, effective utilization of beds, and availability of resources. In order to participate in a provincial program, hospitals or other facilities must be licensed, approved or designated in accordance with appropriate provincial legislation. This system of approval exists at the present time through Hospital Acts which deal chiefly with standards.

Unlike most existing private or non-profit insurance programs, the present proposals place no limitation on length of stay in hospital. The only criteria which will be set on length of stay, will be those associated with medical need. However, if an insured person remains in hospital beyond the period necessitated by medical consideration, then the cost of the period of hospitalization beyond that medically required, will not be considered as an insured benefit.

Basic Principles and Requirements

A basic principle established by the federal legislation is that insured services must be available to all residents of a province upon uniform terms and conditions. This principle was considered necessary because substantial public funds will be used to support the program. Therefore it was considered desirable that there should be no discrimination of any sort as far as persons who qualify as residents of a province are concerned.

Under the federal law, there is an exception made for residents of a province who are eligible for similar benefits under any Act of the parliament of Canada or of a provincial legislature, or under an enactment of any other jurisdiction. This means that workmen in industry covered by provincial Workmen's Compensation legislation, who require hospital care because of work-connected disabilities, continue to have this care provided by the Workmen's

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Compensation legislation. Similarly, veterans who are so entitled under the Pensions Act, receive care for war-connected disabilities. There are other Acts which apply and these are listed in the agreements signed with each province.

When the hospital insurance program was being planned, particular consideration was given to existing traditions and patterns of hospital care and ownership in Canada. It was a basic tenet that no change should be made in existing traditions as far as possible. For this reason it was considered highly desirable to retain the present pattern of hospital ownership, and this principle has been accepted as an important concept in the development of the program.

At the present time many hospitals are operating at a deficit, and it is with regard to hospital operating costs that the new program will have its greatest effect on hospitals. The operating costs of hospitals will now be largely met by this plan.

Both constitutionally and traditionally, matters of health fall within the purview of provincial governments. The hospital insurance and diagnostic services program has been designed to maintain this tradition. Each province will decide on the method of administration and of financing the provincial share of costs. These methods will be described by the province and included in its agreement with the federal government. It is anticipated that there will be variations in the methods of provincial administration brought about by the techniques favoured by a particular province and the degree of development of health resources within that province. Because of these variations the federal legislation has been couched in general terms. It provides for a basic uniformity but at the same time allows for flexibility in the development of provincial arrangements. It will also permit changes in approach in the future, consistent with progress in health care.

Some of the basic requirements of the federal legislation applicable to all provinces, are as follows:

The federal Act requires that the provincial law make provision for the furnishing by hospitals of insured services upon uniform terms and conditions to all residents. It also requires that the provincial legislation make provision for the payment of amounts to hospitals with respect to insured services; with respect to the payment for insured services provided to residents outside of the province; and with respect to federal hospitals. The federal Act also requires that the province make adequate arrangements for the maintenance of standards in hospitals. In addition, the provinces are required to maintain records and accounts, and to permit audit of these by, representatives of the federal government. With the exception of these basic provisions, however, the provinces are given considerable latitude in the setting up of their programs in a manner deemed to be most suitable in each case.

Scope of Services

The federal law lists specific in-patient and out-patient services to which the federal government will contribute. The in-patient services listed in the Act mean all of the following services to in-patients:

- accommodation and meals at the standard or public ward level;
- necessary nursing services;
- laboratory, radiological and other diagnostic procedures, together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;
- drugs, biologicals and related preparations as provided in an agreement*;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- use of radiotherapy facilities where available;
- use of physiotherapy facilities where available;
- services rendered by persons who receive remuneration therefor from the hospital; and
- such other services as are specified in an agreement.

Unlike the in-patient services, the out-patient services are wholly optional, and a province may choose all or any of the services listed for in-patients, and extend these as out-patient benefits. For example, a province may include a complete over-all out-patient service, one or two specific out-patient benefits, or no out-patient services at all. In all circumstances, both the in-patient and out-patient services which a province proposes to provide will be listed in the agreement.

Since this paper was delivered, the Hospital Insurance and Diagnostic Services (Amendment) Act was passed, amending this paragraph by adding the words "when administered in the hospital".

Federal Contribution

The federal legislation contains a formula upon which the amount of the federal contributions to the provinces will be calculated. This formula relates, in the first instance, to the cost of in-patient services, and takes into account national per capita costs and provincial per capita costs. It is calculated as follows:

The aggregate in that year of (a) 25 per cent of the per capita cost of in-patient services in Canada, and (b) 25 per cent of the per capita cost of in-patient services in the province less the per capita amount of authorized charges in respect thereof; multiplied by the average for the year of the number of persons in the province who are eligible for and entitled to insured services at the end of each month in that year.

In practical terms, this entails the calculation of costs both for Canada as a whole and for particular provinces. The precentage of federal contributions to provincial costs will be approximately 50, with low cost provinces receiving a higher percentage, and high cost provinces somewhat less. In determining the amount of the federal contribution with respect to out-patient services, the same percentage will be paid to the province as the percentage of the federal contribution is to the cost of in-patient services in the province.

Starting Date*

Before the prorogation of the last session of parliament, the Minister of National Health and Welfare announced the intention of the government to introduce an amendment to the Act, to en-

Since this paper was delivered, the Hospital Insurance and Diagnostic Services (Amendment) Act was passed, enabling the federal government to commence making contributions as of July 1st, 1958. Agreements were completed with the provinces of Newfoundland, Manitoba, Saskatchewan, Alberta and British Columbia, all of which inaugurated programs pursuant to the Act on that date.

able the federal government to begin making contributions to the provinces, on July 1, 1958.

In the present Act, it is specified that federal contributions will not be paid until at least six provinces, containing at least half of the population of Canada, have entered into agreements with the federal government, and until the provincial laws relating to those provinces, are in force. In effect, this would have precluded the initiation of federal contributions until at least one of the two most populous provinces were prepared to put a provincial program into operation. One of these provinces, Ontario, has already promulgated the requisite legislation, and has entered into an agreement with the federal government. However, Ontario will not commence its

(continued on page 98)

Services

R. MacD. Black

MY PURPOSE is to present the Nova Scotia plan in broad outline, telling what it is going to mean to our hospitals, to our medical profession, and to us as citizens. The services provided are the starting point—the plan. Everything else is ancillary.

In our province, the broadest hospital insurance plan possible is contemplated, with nothing feasible left out. We can be proud of this aim, for, judging from plans already announced, ours should be about the highest level of service in the country. No other announced plans yet exceed our own.

How did we decide upon these services? The level that can be provided in any one province is controlled by three governing factors—the federal limitations, the economic limitations (*i.e.*, the province's position concerning non-sharable items), and the personnel and facilities available. Therefore, steps taken to provide the proposed Nova Scotia plan concerned many individuals and several organizations.

First, there was the interim committee appointed by the government which did yeoman service. The committee report, found to be extremely worthwhile, was referred to time and time again. Next, there were the many meetings of the commission, and the four or more meetings the commission had with its 12-member advisory committee. This last committee had wide representation from the various groups concerned—including nurses, hospitals, municipalities, labour, doctors, the Women's Institute—and other interested bodies such as the Federation of Agriculture.

The commission was also most fortunate in having the counsel of the health committee of Nova Scotia's medical society, headed by Dr. MacRae. Much aid was provided by the executive of our own Nova Scotia section of the M.H.A. Public hearings were held in three central places in the province, and briefs were received from many organizations. The commission had conferences with many individuals, with the other provinces, and, of course, with the federal authorities. We were even able to meet on several occasions with the cabinet of our own government.

This provided the background. Now, I will look at the services themselves. In-patient services will be comprehensive, and will include (as far as I know now) everything that is offered by the dominion. The following is an enumeration of the contemplated out-patient services:

- The laboratory examinations now provided free of charge by the Department of Health's diagnostic services program.
- Electroencephalographic examinations and interpretations.
- Diagnostic procedures involving the use of radio-active isotopes and interpretations thereof.
- Use of radiotherapy facilities, where available, for the treatment of malignancy.
- Use of physiotherapy facilities at the out-patient centre in Halifax.
- For emergency diagnosis and treatment within 48 hours of an accident: (a) necessary laboratory and diagnostic procedures, electrocardiograms and electroencephalograms, together with the necessary interpretations for the purpose of assisting in emergency diagnosis and treatment; (b) use of operating room and anaesthetic facilities, including the necessary equipment and supplies; (c) necessary nursing services; and (d) routine surgical supplies.
- Radiological examinations of any or all of the following portions of the gastro-intestinal tract; oesophagus, stomach and duodenum, small intestine, and colon.

This listing is not final, and although it does not include all the services possible under the federal legislation, it is in excess of the known plans of any other province.

I am pleased to point out that some level of service (as high as possible) is contemplated for an eligible resident when he or she is out of the province. Discussions are going forward on reciprocal provisions between provinces, and decisions are now being made on what will be covered in this regard. In summary, I am able to say that, with the exception of the limitations on the out-patient services, this is a complete plan—prepaid and for all residents. There is no time or age limit; there are no restrictions for pre-existing conditions. The coverage will not lapse for residents.

We are frequently asked why there are restrictions at all. I have already referred to the limitations under the federal Act and to those restrictions on the out-patient level. The simplest answer concerning restrictions is this: we do not now have sufficient personnel and facilities to institute every possible or desirable service. There is general agreement by all concerned that the level of services should be increased as soon as personnel and facilities are available.

Let us speculate now on the effect of this new plan. Hospitals are under no compulsion to join the plan, but, for practical purposes, patients will normally go to those institutions where the services are pre-paid. One significant result of the plan will be the removal of the backbreaking burden of operating deficits that our hospitals have endured for so many years. Undoubtedly, there will be an increase in construction, and, if the situation in the operating provinces is any guide, standards of hospital care will rise.

No one should minimize the pressures that will be on hospitals, in the form of demands for admission, disruption of present procedures, and acceptance of new and perhaps difficult concepts. But,

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Mr. Black is chairman of the Nova Scotia Hospital Services Planning Commission.

(and this is not arguable) the result will be conditions that are far less burdensome. Easier operation will be inevitable, and, despite the present misgivings on such matters as capital, there will be a very substantial general improvement.

There will be pressures on the medical profession as well—indirect pressures. Except for the part giving traditional hospital diagnostic services, the profession will not be directly affected. However, all practising physicians in this province may experience an immediate pressure for admissions, which may continue until the construction programs are completed. However, the doctors will also benefit, since now many of them cannot get their poorer patients into hospitals when they would like to have them there. Improved standards and better facilities will provide working conditions far superior to anything our doctors have experienced so far in hospitals across the province. The surgeon and the family physician will go on as before, since this is not a medical plan.

What will be the effect on those who will receive the services? Here the greatest benefits of all are going to be received. Gone will be the fears and burdens of the catastrophic hospital bills of the past. This plan was evolved specifically for the people of this province, and it cannot help but be a godsend in many instances.

In conclusion, I repeat that the services are there, and the services make the plan. There will be a very heavy responsibility not only on our medical profession, but on the people responsible for hospital operation as well. The early years may be difficult, but I think everyone can readily appreciate the great benefits to come, realizing that by co-operation and good faith, difficult transitional periods will be eased and the benefits will come sooner. Those of us on the commission freely predict that this plan will be the greatest social advance in the history of our province. It cannot help but affect every one of us. It cannot help but improve the situation of our hospitals and remove many inequalities which now exist.

The heaviest burden is perhaps to be on the people in hospitals, but I know that they will accept the responsibility with good heart in order to contribute to the well-being of all our people.

Bed Requirements

C. B. Stewart, M.D.

MOST of my experience with the hospital insurance plan in Nova Scotia has been in estimating the bed requirements. In case some of you may wonder why a man who has had no experience in hospital administration, or any other aspect of hospital services, should be delving into hospital bed requirements under a hospital insurance plan, let me tell you quite frankly that it was accidental.

In 1948 the federal government made ten grants to the provinces for assistance in various public health activities and in hospital construction. Most of these grants, which still continue and, in fact, have been expanded, were to assist in specific fields of public health such as tuberculosis, cancer, crippled children, et cetera. However, one grant was for a survey of the health facilities of the province. I had at that time been only recently appointed to the staff of Dalhousie University in the Department of Preventive Medicine and was asked to serve on a part-time basis as director of a health survey of Nova Scotia, working with a large committee representing various agencies interested in public health, labour, municipalities, et cetera.

Since my training was in the field of public health, I accepted this interesting assignment without looking too closely at the "fine print". When I did study the terms a bit more closely, I realized that the federal government had asked the provinces to do a survey of all health facilities, including individual medical, hospital and nursing services, as well as public health programs. Recommendations on the desirability and feasibility of health insurance and hospitalization insurance in the province were specifically asked for. It was suggested that one of the first requirements in Nova Scotia would be to obtain some estimate of the needs of the hospitals should a system of hospitalization insurance come into effect.

One surprising thing was to find how little one could learn from the medical and hospital publications about the needs of the hospitals under an insurance plan. Almost everyone predicted that there would be an increase in hospital services under an insurance plan, but very few people tried to estimate how much increase. Yet one of the major reasons set forth for a government-financed hospital insurance plan was the feeling that many people needing hospital care were not getting it because of the cost. The other major "pro" argument was that the hospitals were having increasing financial difficulty in providing as much service as they were then giving.

Obviously it is essential to estimate how big an unmet need for hospital services there is, or to put it another way, how much hospital service will be demanded or required under a plan. A few standards were proposed some years ago in the United States which suggested that four beds per thousand population, or 4.5 beds per thousand population should be adequate. When one looked at the original publications in 1949 it became clear that these estimates were a goal at which people were aiming when they had far fewer hospital beds than this ratio. There was little indication that the provision of hospital services would, in fact, be adequate for the population when the ratio was reached. However, there were already some other indications of the needs under insurance in 1948 and 1949. Some fairly large population groups had recently been insured for complete hospital care. The Saskatchewan Hospital Services Plan had begun in 1947. By 1949, when our first survey of the hospitals in Nova Scotia was completed, Saskatchewan had informed us that the increase in the volume of services already seemed to be levelling off there. We also found in our own province that Antigonish and Guysborough Counties had a much higher proportion of the population insured under Blue Cross Hospital Insurance than did any other area in Nova Scotia. Cape Breton also had considerable insurance coverage under the check-off plans. The average proportion of insured people under Blue Cross for the whole province was about 20 per cent,

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while in Antigonish County it was approximately 80 per cent, and was almost as high in Guysborough. It was very interesting to note that these two counties which had voluntary insurance for hospital costs had already provided themselves with almost as large a volume of hospital services as the people of Saskatchewan where 100 per cent were insured under a government-sponsored plan. Cape Breton also had a high rate of hospitalization.

This information gave us a clue as to the probable ceiling hospital services might be expected to reach in the whole province under a comprehensive insurance coverage. Since that time we have had very little reason to change our opinions on this matter because the Saskatchewan Services Plan has continued to operate at a fairly stable level. The British Columbia services also increased, or are increasing to very much the same level, and other areas which have been provided with insurance also have increased services which level off at about the same point.

This ceiling can be expressed in several ways. One measure of the volume of hospital services is the number of people who are admitted to hospital each year. This is usually calculated as a rate per 1,000 population. In round numbers it may be stated that approximately 200 to 210 people out of every 1,000 in an area where there is complete hospitalization insurance are admitted to hospital during the year. The average stay is approximately ten days per patient; so another way of expressing this ceiling is that approximately 2,000 to 2,200 patient days per 1,000 population would be required for these 200 patients. We have taken the figure of 2,150 patient days as being a reasonable ceiling for Nova Scotia. Patient days can be calculated back to give another figure which is also sometimes quoted; namely, the number of hospital beds per 1,000 population. In making such a calculation one has to take into account the fact that hospitals cannot be filled 100 per cent all the time. A 100-bed hospital can hardly operate at any more than an average occupancy of about 75 per cent over a period of a whole year. Larger hospitals may have an 80 per cent bed occupancy, and small ones of 20 to 50 beds may run at a 40 per cent occupancy.

In simple terms we would then say that under an insurance plan a fairly rapid increase would occur in the hospital services in Nova Scotia. This increase will probably level off after two or three years at a ceiling of about 2,150 patient days per 1,000 population. With an average stay of about ten or 11 days, this ceiling will allow about 200 persons out of every 1,000 to have hospital care during the year. To provide this service we will need 7.5 beds per 1,000 population at an average of 75 per cent bed occupancy. The subtraction of the number of beds in D.V.A. hospitals, (chiefly Camp Hill in Halifax) and the military population, reduces this ratio in Nova Scotia to 6.9 beds per 1,000. These beds should be divided so that approximately 5.5 per 1,000 will be in active treatment general hospitals and 1.4 in regional long-term hospitals. In 1956 we had almost 409 beds per 1,000 population, and the increase must therefore be appreciable to bring this to 6.9. An additional 2,106 beds will have to be provided. In some regions the bed ratio is already quite good, particularly in Antigonish, Pictou, and Guysborough Counties, and Cape Breton Island. The lowest ratio of 2.2 beds per 1,000 is in the western region.

Do we expect that all areas of Nova Scotia will demand the same level of hospital care? Of course, many factors enter into answering this question. The doctors' habits in the use of hospital services are of importance. In some areas of this province only about 50 per cent of the mothers have their babies in hospital; in other parts of the province it is about 99 per cent. Some racial groups have different customs about calling a doctor or going to hospital. In some areas the old fear that the hospital is a place where the seriously ill person is taken to die still lingers. In others, the hospital has become so popular that it is treated almost as a resort hotel where one may go for a rest. Differences from one area to another may actually result in different ceilings—some areas demanding more than 2,150 patient days of care, and some, perhaps, considerably less. It is therefore very much a guess as to what this ceiling will be in any particular region. The figure of 2,150 should then be considered only as an average goal, not as a standard for which all should aim.

It would seem reasonable that in the regions which have a relatively low hospitalization rate today (such as the western area), one would not expect a threefold increase in hospital services within one or two years. If there is an increase all the way up to the ceiling of 2,150 patient days it will probably be gradual. It may, too, even stop short of that total. This suggestion has a practical bearing on the number of beds to be provided. We may eventually need 6.9 beds per 1,000 on the average, but in the areas that are very poorly supplied today the building may be done step by step so that there is no over-building of hospital beds. Building should be planned so that additions can be added if they are required.

Type

Another aspect of hospital bed requirements concerns the type of accommodation. There are, in fact, still three types of institutions needed to provide general hospital services, even when the special types of hospitals, such as mental hospitals and tuberculosis hospitals, are excluded. Most of us think in terms of the *active treatment general hospital* with which we are so well acquainted, but *chronic or long-term hospitals* and *nursing homes* are important too.

The active treatment hospital for acute or short-term patients provides obstetrical services; takes care of the acutely ill, the injured, the person requiring elective surgery; but it does not ordinarily have sufficient beds to permit the long period of hospital care beneficial in certain chronic illnesses, such as arthritis, chronic heart failure, cerebro-vascular diseases, et cetera. Only the very large hospitals have the special kind of personnel (such as physiotherapists and occupational therapists) and facilities to help these people to the greatest advantage.

The second type of institution is one which is hardly known today in Nova Scotia, except, in embryo, in the Nova Scotia Rehabilitation Centre which has recently been established in the Halifax Tuberculosis Hospital. This long-term hospital is also an active treatment hospital and is not to be considered just a custodial institution where incurables are sent. Because of the nature of the illnesses and the type of treatment, the progress may be long and slow, and often complete function may not be restored. How-

ever, this patient should be provided with hospital care, and the special personnel should be available to treat him so long as he is capable of improvement. When such improvement ends he should be discharged either to his home or to a nursing home. An exception may be the terminal case requiring extensive nursing and medical care.

There is, of course, obviously an overlap between these two types of institutions, but the important point is that the chronic hospital is not a custodial institution where incurables are allowed to vegetate. The true chronic hospital requires almost all the specialized services that the general hospital does, as well as specialists in physical medicine, physiotherapy, and occupational therapy. In the large regional or provincial centres, specialists in speech therapy and other specialized technical or professional staff will also be needed.

There can be no doubt about the need for such chronic hospital services. Many people who were considered as permanent cripples and a burden on the community have been rehabilitated so that they can, at least, care for themselves, and once more earn a living. Some people speak of chronic hospitals as though they were cheap to operate and very low in initial capital cost. If they are thought of in the way I described, it will be seen that they will be almost as expensive as the acute general hospital.

The third type of institution is the nursing home which will provide for the incurable, the bedridden who cannot be rehabilitated and the feeble elderly person. Unlike the chronic hospital, it does not require very many special services or highly trained personnel. It can be, and preferably should be, a small unit of less than 20 beds, located in as many small communities as possible so that the patients will be near their homes and their friends.

It is important to emphasize that the provision of nursing home services is not covered by the present insurance plan. Nevertheless, it is important, I think, to realize that if patients who could be cared for in such nursing homes do not have such facilities provided for them in their own communities or in their own homes, some of them will tend to stay in the chronic and acute general hospitals for lack of any other place to go. It is therefore interesting and important to note that provision is being made in Nova Scotia for the registration of nursing homes. It is hoped that these will be provided in many communities and will be able to relieve the hospital insurance plan of patients who really do not need, or cannot benefit from hospitalization, but who still need some type of simple custodial care.

This article has over-simplified some aspects of the problem of estimating the type and number of hospital beds, but it may serve as a general guide. Any area planning a new hospital should consult with the Planning Commission and have the estimates brought up-to-date, since the figures presented here are based on population statistics, patient days per hospital, and other data which has already changed considerably.

Personnel

H. F. McKay, M.D.

ONE of the most complicated problems the Hospital Services Planning Commission had to deal with was that of personnel. The assessment of the present personnel situation and the projection of future needs in all classifications of hospital personnel is complex. It is not my intention to deal with any but professional and technical personnel in hospitals, and in dealing with these it is necessary that the figures on which surveys are based be analyzed.

The figures on nurses are based on the survey carried out in 1956 by Jean C. Church, M.Sc., R.N., and Rhoda F. MacDonald, R.N. In turn this survey and report was reviewed and revised by Florence Gass, R.N., Sister Catherine Gerard, R.N., Dr. C. B. Stewart, Dennis Mantin, B.Com., and others. It has been estimated that the average necessary amount of nursing service per patient day is between 3.4 to 3.5 hours. These figures include the time of the supervisory staff and administration and clinical supervision on the ward, as well as bedside care. It has been determined that a ratio of one nurse to 1.8 hospital beds is needed to provide a satisfactory level of bedside care, plus the necessary ward administration and supervision in active treatment units. In chronic treatment units it has been estimated that a ratio of one nurse to three hospital beds is necessary to provide a satisfactory level of service. In these calculations and estimates the bed complement is used, rather than the bed capacity, since a bed with a patient requires nursing care whether it comes within the capacity or within the complement.

The assumption that the average student nurse, because of incompleteness of training and experience and because much of her time is taken up with lectures and demonstrations, can provide only one-third of the service of a graduate nurse is also made in these tables.

In 1956 there was a nursing staff of 929 graduate nurses, 349 nursing assistants, and 945 student nurses to serve a hospital bed complement of 3,623. This gave a final ratio of 2.27 beds per nurse. In 1957 there was a significant improvement in this ratio which was estimated as 2.18 beds per nurse.

In appraising the situation in Nova Scotian hospitals, many factors became apparent. Table 1 shows the personnel position in Nova Scotian hospitals. It has been suggested on a somewhat arbitrary basis that the nursing staff of any hospital might have a ratio of two graduate nurses to each nursing assistant, and in chronic treatment units three nursing assistants to each graduate nurse. As nursing assistants can be trained more rapidly than graduate nurses, more can be made available each year. There is another factor too; it appears that nursing assistants stay with hospitals in a much higher percentage than do student nurses when they become graduates. The Commission figures show that some 21 per cent of student nurses remain with hospitals as graduates in the province, while the figure for nursing assistants is materially higher. The schools for nursing assistants in Nova Scotia are mainly in specialized hospitals — the Nova Scotia

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Sanatorium, The Nova Scotia Hospital, Camp Hill Hospital, and more recently, St. Martha's Hospital has opened a school for nursing assistants. The figures from the first three schools indicate that the majority of nursing assistants remain with the hospitals in which they trained. However, about 40 per cent could be made available to general hospitals in the province. This figure of 40 per cent for nursing assistants compared to the 21 per cent for graduate nurses is indeed a contrast.

Between 110 and 120 men and women gradute from provincial schools for nursing assistants each year; 40 per cent of these would indicate that approximately 45 nursing assistants might be available each year for general hospitals. In contrast to this, in 1956, there were 945 student nurses in our Nova Scotia schools of nursing and a recapitulation of this figure indicates that some 52 of these remain as graduates in general hospitals each year.

From the first two columns following the graduate nurses and the nursing assistants it can be seen that from the basis from which these figures were set up, there is no apparent shortage of graduate nurses. There is, however, a shortage of 232 nursing assistants. Projecting these figures to 1965, and assuming that the beds as recommended in the Stewart report on bed requirements in the province of Nova Scotia are met, we can discover that there will be a graduate nurse shortage of 441 in 1965. There will at that time be a nursing assistant shortage of 678. If it were proposed that hospital staffs were to be made up entirely of graduate nurses in 1965, there would be a shortage in excess of 1,100. With the present gain of 52 nurses a year from schools of nursing within the province, it would take over twenty years to meet this demand. If schools of nursing in the proince were doubled in size, it would still take ten years to meet the demand. For this reason, it would appear that the only logical solution is to use nursing assistants more than at present.

In the event that provincial hospitals are willing to use the services of trained nursing assistants to greater degree, the provision of some 52 graduates per year from the schools of nursing would, by 1965, almost meet the shortage of 441. If present training schools were expanded, this shortage of 441 could very well be met. There is no way of telling exactly why, with over 300 student nurses graduating each year in Nova Scotia, only 20 per cent remain in the nursing profession. One can only conjecture that conditions of employment, salaries, living conditions, and various other factors in hospitals play some part in the picture. If this is correct, one would think that the provision of more adequate living quarters and recreational space in nurses' residences might in part alter this situation to the point, where, perhaps, 30 or 33-1/3 per cent of these graduates would remain with hospitals. Certainly the Church-MacDonald report indicates that in many areas of the province nurses' residences are woefully inadequate.

Nursing assistants at the present level of training would, by 1965, make some 370 additional nursing assistants available—this would still leave a shortage of 300. An expansion of existing training schools for nursing assistants would make available more personnel at the end of the year than an expansion of existing training schools for nurses, which would not realize additional personnel for three years. Therefore, the Commission feels that it is more desirable to expand existing schools for nursing assistants at this time than to expand, to any great degree, schools of nursing. Also it is more desirable to establish new schools for nursing assistants than to establish new schools of nursing. The nursing profession and the hospital association, the Commission has suggested, might do well to look into this as a joint effort.

More attention than has been paid in the past should be given to the older age group: for example, married women of 35 or over; mothers whose families are becoming independent — such women are mature, experienced and apt to remain in the community. Personnel policies for the non-professional group must be given careful attention if they are to be attracted and held. This means that such things as housing and remuneration, both during and after training, must be reasonable and proper.

One of the most serious defects in the training program for nurses and nursing assistants today is the shortage of qualified directors of schools, as well as one of teachers and supervisory personnel. At the present time there is a need for 35 qualified instructors; about half of whom are needed in the clinical field. It is obvious that a very vigorous recruitment campaign must be started, and that the position of the instructor in the school of nursing must be made attractive enough to provide the required personnel. The Commission feels that this is another field in which co-operation between the Registered Nurses' Association and the Nova Scotia section of the Maritime Hospital Association is urgently required; and it is our understanding that

Table 1

Personnel Position in Nova Scotia Hospitals

	Present (1957)			Future (1965)	
	Required	Available	Shortage	Required	Shortage
Graduate Nurses	1264	1265	+1	1706	441
Nursing Assistants	625	393	232	1071	678
Student Nurses		945 (1956)	(Est. 52 grads per year increase)		
Schools of Nursing, (Instructors)	7475	35/40		70/75*	35
Dietitians		22 + 2 part time		44	22
Medical Record Librarians		11		26	15
Physiotherapists		11	(Est. one for each additional regional hospital)		
Occupational Therapists		3	(Est. one for each additional regional hospital)		
Pharmacists		7	(Est. one for each hospital over 75 beds)		
Medical Social Workers		6	(Additional for each regional hospital)		

*N.B. The qualifications of all present instructors are not known, but it is probable that all do not have full qualifications. It is possible, therefore, that the requirements for fully qualified instructors is in excess of these figures.

attractive bursaries will still be available under the hospital insurance plan.

Dietitians

The science of dietetics has proved itself of such therapeutic value in disease that at least every hospital over 50 beds should employ a dietitian if at all possible. In as much as food expenditure involves approximately one-third of the total expenditure of the hospital, the hospital which cannot afford to employ a dietitian is under a distinct economic and therapeutic handicap. As of January 1958 there were 22 full-time and two part-time dietitians employed in hospitals of the province, distributed as follows: Victoria General Hospital—8, Halifax Infirmary—5, Children's Hospital in Halifax—2, with one instructing at Payzant Memorial Hospital in Windsor. There is one part-time instructress at each of the following: St. Elizabeth's Hospital, North Sydney; St. Rita's Hospital, Sydney; St. Joseph's Hospital, Glace Bay; City of Sydney Hospital, Sydney; St. Martha's Hospital, Antigonish; Highland View Hospital, Amherst; and Aberdeen Hospital, New Glasgow. In 1965, if additional hospital beds are constructed as suggested in the Stewart report, it will be reasonable to assume that the present available staff of dietitians would have to be doubled.

At the present time in Nova Scotia, basic academic training in dietetics is available at Acadia University, Mount St. Vincent College, and St. Francis Xavier University. A dietetic internship of one year is then required. The Halifax Infirmary and the Victoria General Hospital operate approved schools for dietetic interns. The Halifax Infirmary could train up to four interns, but at present has no interns enrolled in the course. The Victoria General has, since 1954, trained ten interns, but only one of these is now employed in a hospital in Nova Scotia. The Vocational School in Halifax provides a course for dietetic aides. At present the requirement for entrance is grade X, the course is of two years' duration, and enrolment averages about four a year. It is apparent that the serious shortage of dietitians warrants careful study and research. It is likely that among the corrective measures indicated by the study, there will be more intensive re-

Table 2A

Laboratory Personnel

Actual January 1958—Estimated Requirements, 1959 and 1965

Hospitalization Plan—Nova Scotia

Region	Registered Lab.		Technicians		Other Lab. Technicians (1)			Professional		
	Jan. 1958	1959	1965	Jan. 1958	1959	1965	Jan. 1958	1959	1965
Cape Breton	10	24	34	13	10/1½c(2)	10/1½c	3P (5)	4P	4P
Eastern	4	5	6	1	1/1½c	1/1½c	1P	1P	1P
Pictou	3	6	7	2	1	1	1P	1P	1P
Cobequid	3	3	6	0	1c	1/1c	0	1P	1P
Cumberland	1	4	6	2	1/1½c	1/1½c	0	1P	1P
Fundy	1	6	14	0	1	1/1c	0	1P	2P
Western	3	5	9	1c	1c	1	0	0	1P
Southern	2	3	8	0	1	1	0	0	1P
Atlantic A (3)	8	13	18	1	2/½c	2/½c	1P	2P	2P
									1C
Atlantic B (4)	47	52	54	12	13	14	4P	4P	4P
							2C (6)	2C	2C
							1H (7)	1H	1H
							1B (8)	1B	1B
							½V (9)	½V	½V
Totals	82	121	162	31/1c	30/7c	33/7c	10P	15P	18P
							2C	2C	3C
							1H	1H	1H
							1B	1B	1B
							½V	½V	½V

cruitment campaigns and better personnel policies. The latter is particularly important if candidates are not to be lost to industry and teaching, where better living conditions and salaries are offered.

Medical Record Librarians

The medical record is a very important document to the hospital, the patient and the attending physician. In 1957 there were 11 registered medical record librarians in the province, found in the Aberdeen, Halifax Infirmary, St. Rita's, St. Joseph's, St. Elizabeth's, St. Martha's, and the Victoria General Hospitals. It is obvious that there is a definite shortage, if it is assumed, on the more or less arbitrary basis, that there should be at least one registered medical record librarian in each hospital of 50 beds or over. There then would be a minimum potential need for 15 additional medical record librarians by 1965.

At the present time there are six approved schools for medical record librarian training in Canada. The total capacity of these schools is only 41 annually, and only one of these schools is situated east of Quebec; *i.e.*, the Halifax Infirmary. Student capacity at the Infirmary is four, and the record of the Infirmary over the past three years has resulted in the training of 14 librarians. The Victoria General Hospital has for some time been considering opening a school, and the new records department, soon to be completed, will mean that a school at the Victoria General Hospital may well be feasible by 1959. Because of the shortage of trained personnel in medical record librarian's work the Canadian Hospital Association and the Association of Medical Record Librarians jointly provide a two-year extension course of home study in hospital practice for those employed in medical record departments, but who have not received training in this field. The provincial Department of Health, because of the lack of trained staff, has made national health grant bursaries available for both the formal 12-month course and the extension course. From 1954 to 1958 inclusive, nine bursaries were awarded for the formal 12-month course and five for the extension course. Here again, the need is easily recognized for extensive recruitment campaigns.

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Control of Standards

G. G. Simms, M.D., D.P.H.

THE control of standards of care in the hospitals of this province has been in the hands of competent and devoted people for many generations. Therefore it is with some trepidation that I set myself the task of outlining the proposals of the Commission regarding the presentation, and even elevation, of these standards. As the control of standards (or, if you like, quality) of care is a delicate and difficult matter, it seems advisable to develop my points in a logical (and I hope) clear manner.

Firstly, our basic premise is that the control of hospital standards, like all other matters pertaining to the functioning of a hospital, is to be left in the hands of the hospital authorities to the *maximum degree* compatible with the operation of a provincial hospitalization plan. To what are we referring when we speak of the control of standards?—standards of what? The answer, of course, is standards of professional care of the patient.

What departments in the hospital have to do with professional care? These are the medico-administrative group, comprising medical social services, admission and discharge, and medical records; the medical services, including the attending and resident medical staffs and the adjunct diagnostic and therapeutic departments; the nursing and the dietary services.[1*]

It is quite obvious that many departments of the hospital, and therefore many persons in diverse fields, are directly concerned with the professional care provided to the patient. Indeed, one might take an even broader approach to the matter and say very truly that even the attitude of the maid who dusts the patient's room has a bearing on the well being of the patient — a dyspeptic individual with a chronic snuffle, wielding a tattle-tale grey cloth, does nothing for a poor patient striving manfully to bear up under post-operative gas pains.

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**For references see page 99.*

With so many individuals involved in the professional care of the patient, what individual or group of individuals is ultimately responsible for the standard of this care? Among the duties of the governing board of a hospital, as defined in the *Code of Ethics* of the American Hospital Association and the American College of Hospital Administrators, there are listed the following:[2] (a) to see that proper professional standards are maintained in the care of the sick; (b) to surround the patient with every very reasonable protection, thereby fulfilling the moral and legal responsibility of the board.

From the foregoing, it would appear logical to assume that, although many persons in the hospital are concerned with the standard of professional care provided to the patient, and at least morally responsible for the care they provide, in the final analysis it is the board of the hospital that is responsible for the standard of care received by the patient.

All this has been rather elementary and has introduced no new factors into the situation. However, it perhaps has reviewed the present status, and has painted the backdrop for the entry of the new factor—the proposed provincial hospitalization plan. The big question is—"what rôle is this untried and unknown character to play in the control of the standards of care?" While the present "character" is untried and unknown, it has had counterparts both in Saskatchewan and British Columbia, particularly the former, which have been well tried and well known. Although it is not necessarily valid to believe that the outstanding results of the standards control program of those other provincial hospital plans will be duplicated in Nova Scotia, I am suggesting that you credit us, as a Planning Commission, with the sincere intention of at least striving to emulate them.

Specifically, and disregarding protestations of good intentions with which the broad highways to the nether regions are said to be paved, what actually would be the position of the proposed Hospital Insurance Commission in standards control? Having stripped away all

legal jargon, it may be said that legislation now before the House provides that the Governor-in-Council may make regulations regarding standards of care, and that the proposed hospital insurance commission is "to administer the plan for providing insured services established by the regulations".

If it is clear that the Governor-in-Council may make regulations regarding the standard of care in hospitals and that the commission would be the executive authority, the next and very important question is, "What will be the provisions of such regulations?" Actually, this is a question that no member of the Planning Commission is able to answer with authority, for the good and sufficient reason that no regulations are in existence. However, there is merit in reviewing and expanding the recommendations of the Commission.[3]

The opening paragraph of this section of the Commission Report states: "it is basic to the philosophy of this plan and the unqualified recommendation of the Planning Commission that *authority and responsibility in the largest measure possible should remain with the individual hospitals.*" This was no idle platitude; we were not only "against sin," but we felt that something should be done about it. To be concrete, we felt that the initial and prime control of standards should be in the hospital itself, where it has always been, and where abuses can be best detected and best handled.

In detail, it was and is our opinion that a co-ordinated system of standards control should be established at three levels; namely, the hospital, the region and the province. At the hospital level, the hospital board, as the body ultimately responsible for the standard of professional care, should set up a *hospital standards committee*, whose function would be to ensure, insofar as possible, that a high standard of patient care was maintained and that the use of services was reasonable and proper.

The composition of the hospital standards committee is a matter of considerable moment. Certainly, the hospital board, again as the body ultimately responsible for the standard of patient care, must be represented. Certainly, too, the medical staff, which is so intimately and largely concerned with patient care, must be represented. To quote the authority, MacEachern:

"Through the administrator, the medical staff is responsible to the governing board for the clinical and scientific work of the hospital and may be called upon to advise regarding professional problems and policies. To promote the fullest co-operation between the governing body and the medical staff, a joint conference committee is recommended, consisting of representatives from both groups together with the administrator."

The procedure for the audit of purely medical matters by such a joint conference type of hospital standards committee is a matter of some proper concern to the medical profession. Sound judgment would dictate that only the qualified medical practitioner, having in mind what is good medical practice and the standards of the hospital, can properly perform a medical audit.

It would seem to follow that the hospital standards committee would have representation from both the board and the medical staff, and that the medical staff members as a subcommittee, would review and advise the committee on matters of primarily medical concern.

In the case of some of our smaller hospital, there would be many obvious difficulties in the way of the effective operation of a hospital standards committee. However, without going into detail, it is considered that effective standards control, with major participation at the hospital level, could be established by consultation and assistance from the provincial level.

At the regional level, it is our thought that there should be set up by the proposed hospital insurance commission a *regional standards committee*. In some instances it might be more effective to combine two regions for this purpose. Each hospital should have representation in this committee; such

(concluded on page 99)

Financial Control

Walter W. B. Dick

FINANCIAL control is an aim of administration in every effort organized to serve society. With equal force, this observation holds for the non-profit charitable institution, like the voluntary hospital, as well as the commercial concern motivated by profit. It may, therefore, be properly assumed that the general principles for financial control applied in business would be appropriate in hospital affairs.

Another fundamental premise is that accounting is the means available for attaining financial control. However, before diving from this springboard of propositions right into the accounting devices useful for control purposes, a few preliminary remarks are called for.

It is obvious that if control is to be effected, certain conditions must prevail. In the first place, the controller should know the aims and objects of the organization. For example, in the case of the voluntary hospital, care should be provided at cost and no one requiring service should be turned away because of his inability to pay. This conditioning emphasizes the need for service rates related to costs and for the soliciting of donations, grants, and/or reimbursement for indigent patient costs. At the same time, there must be recognition of certain standards of care, as exemplified in the accreditation program. Another condition involving cost is the emergency stand-by services provided by the community hospital. A further requirement is that administration must at all times be aware of and alert to the financial facts pertinent to operation. These are but a few of the conditions.

It is self-evident that administration must not only be well informed, but must have an important attribute—experience. It is a truism also that a proper mixture of knowledge and experience with ability should produce the wisdom necessary for making foresighted decisions which realize objectives. This is to assure, as well as to warn, that accounting is not the only force involved in establishing and maintaining financial control. Nevertheless, it is axiomatic that the desirable degree of control essential for efficiency in the mod-

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ern hospital can only be realized with adequate and appropriate accounting.

Early in life we are told that we cannot add peaches and pears to a significant total. Later, we learn that if we give peaches and pears a price we can bring the determined money values to one meaningful total. Accounting, which recognizes the use of the dollar tag on economic activities, and which applies the debit and credit double entry techniques, provides the means to measure and communicate financial information which reveals the results of human motivations and judgments.

We have deliberately referred to the double entry technique not only because, in itself, it is so profound that it has attracted the attention of world thinkers, but because its application automatically gives a control over the resources under administration. Today there is a general recognition of the fact that financial statements, such as the conventional balance sheet and operating statement, are best interpreted and understood by those who have had formal training as well as extensive experience in the accounting field. Administration without such a background must look to skilled accountants for guidance in making decisions relating to financial control.

This all too brief review of the accounting function attests that not only are the financial facts made available for ensuring that short and long-term plans are achieved, but also that accounting offers the mechanical recording process for control of such assets as land, building, equipment and investments.

The Means

Abbreviated references to some of the means for establishing and maintaining financial control in an institution such as the voluntary hospital is pertinent at this point. Such means may be found within the accounting system, financial statements, cost analysis, budgets, special reports for management, statistics, uniformity, averages, internal check and the audit.

Accounting System

You can do no better than use the type of general ledger accounts presented in the *Canadian Hospital Accounting Manual* because it is developed in keeping with the administrative areas of responsibility generally set up in the acute hospital. This system provides for control at the department level. Furthermore, it is characteristic of accounting to be flexible in application—thus, if financial information concerning various identifiable activities within a department is desired it can be recorded. Attention is also drawn to the fact that not only is financial information available for each department, but for each main type or class of expense or income. The reference here is to such items as salaries and supplies. This provides financial information to administration as the business transaction is incurred. In control it is important to recognize that the business transactions must be recorded as they take place and not when the services or supply is posted in the form of a cash receipt or pay out. Here, then, is a fundamental principle of control often ignored in the past. Presumably, any dereliction from the principle advocated here will not be tolerated in the days ahead. At any rate, administration will not be able to afford to ignore the practice of recording service or supply use at the time of application or consumption.

Naturally throughout CHAM there is recognition of the non-profit, charitable objectives of the hospital. For obvious reasons, the word "profit" finds no place in the terms used. It should be understood too that generally accepted accounting principles are recommended throughout. This includes the much misunderstood expense items — depreciation on buildings and equipment.

Financial Statements

Coming out of the classified and departmentalized items of income and expense is the statement of revenue and expense—commonly referred to as the operating statement. It is through the various forms of this statement that financial facts regarding operation are communicated to administration. In conveying the message of what happened between balance sheet dates much depends upon the form of this statement. If the arrangement is such that the significant items are highlighted to attract administrative attention, the operating statement can assume a vital rôle in inciting action. This is particularly so if figures are in a comparative form, such as comparisons with a previous financial period or with estimates determined prior to the period of operation being reported upon. Currently this type of administrative attention to deviations from past experience or estimate is referred to as management by exception.

The other common accounting statement is the balance sheet which purports to show the financial position as at a stated point of time, usually at the month or year-end. Just as the operating statement reveals much control information, so does the balance sheet. By relating two successive statements of this type the effect of operations between the two dates is available to the reader. Changes which take place in cash, accounts receivable, inventories, liabilities, fixed assets and equities are significant to the would-be controller.

The statement of application of funds — sometimes referred to as "where got—where gone" statement —is available for this purpose. So also are ratios, such as inventories to supply use, accounts receivable to income, and others of a similar nature. For the most part, the statements referred to here are historical, since they are prepared after the operation is completed. This means that to be most useful they should be prepared as close to the accounting period being reported upon as is practical. For example, if the accounting period is a month, the date or presentation of facts should not be later than the tenth of the following month. Undoubtedly, the currency of financial facts is very important and some accounting authorities have gone so far as to say that accuracy of figures is far less important than the timeliness of the figures. Again, the interpretation of a related series of financial statements revealing a trend will permit an experienced controller to forecast future financial events.

All of this indicates to administration that there is a very useful control tool in general accounting that can be carried out in an institution without becoming involved in any figure frills.

Cost Analysis

Cost analysis is one of the refinements in accounting available to administration for financial control. While it is true that a considerable amount of know-how and additional effort beyond that required for reports coming out of general accounting is needed, it is also true that information is produced relating to the cost of each service. This makes data developed in this process useful as a guide in setting service rates. In addition, if the cost analysis is practised periodically, changed unit costs in the

various services can pin-point variances related to work load and the like.

Substantially, all the work involved in cost analysis is carried out on work papers from information included in the general ledger accounts, and uses the additional statistics prepared for measuring activities in the several departments of the hospital.

It is not a routine procedure at the moment, but well might be when additional trained personnel can be brought on staff for the purpose. The cost information provided would give administration a more detailed knowledge of hospital finances. Therefore it would strengthen administration control over the economics of operation.

Budgets

A budget is one of the most useful, as well as simple, accounting procedures that can be carried out by administration. Actually, the budget represents the essence of control because it purports to show the financial results that come about from planning activities in advance of their occurrence. Undoubtedly, because of its importantance to financial control in hospital administration, any agency reimbursing for care would call for its use.

With some indication of what the future volume of services will be and informative financial statements and statistics of past periods, it is possible to draw up budget operating statements and balance sheets. It is quite likely too that such budget information will be required some two or three months in advance of the year concerned with the care to be provided. This will assist in the financial planning of those who have an interest in reimbursing for patient care.

The budget is not only useful in forecasting future needs, but it also assists in controlling current operations. This is done by comparing the actual cost with the budget for a given period. The control comes from the accounting for the variances in terms of quantity and price of services or goods.

Everything is in favour of the budget as an administrative device directed to the all important function—financial control.

Special Reports for Administration

In our preceding remarks it was suggested that timeliness of financial figures is most important in exercising control. Elsewhere too, it was intimated that it was the significant figures that were of interest to administration.

At any rate, we know that top level administration today finds itself involved in so many personnel problems that any assistance in reducing the details in figure presentation is most welcome. With the factors of timeliness and reduced details in mind, it is suggested that certain figures in report form are required daily, some weekly, some monthly, and a few may satisfy when only prepared in detail annually.

The suggested reports are: *Daily* — cash report, census of in-patients, beds not utilized, hospitalization of employees, and occupancy ratios; *Monthly*—absenteeism, cost per meal served, personnel turnover, and financial statements (balance sheet, income and expense, service statistics); *Annually*—inventory turnover, maintenance cost per in-patient day, nursery hours per patient per day, and post audit balance sheet (income and expense, annual report, detailed report, service rendered). These reports relating to finance and statistics would be the regular and routine reports that would keep administration informed so that control would be most effective.

In addition to the above reports, administration would be informed on the unusual items, such as accidents, that might involve finance. It would be anticipated too that all capital expenditures would be approved by the administration in advance of any commitments.

Statistics

Although the collection of statistical data is not part of the accounting process related to the recording of financial transactions, the figures so collected are very useful in presenting meaningful accounting reports. It is therefore suggested that, whenever possible, statistical records should be maintained in conjunction with financial transactions; *i.e.*, the patient day and the earnings records. The patient days charged in the earnings record should be reconciled to the census days, which in all probability is recorded by another person in another department.

Undoubtedly, the most common statistic used in the hospital is the patient day. In the same area there are the number of admissions, the number of examinations, operations and births. From the service departments are such statistics as number of meals served, number of pieces or pounds of laundry, gallons of fuel oil or tons of coal, to mention a few. Current statistics accurately recorded and reported upon provide administration with knowledge of the volume of economic transactions which, when tied-in with accounting dollars, have significance in determining the effectiveness of financial control.

Uniformity

No two hospitals are exactly similar, but the differences are not sufficiently important to invalidate the usefulness of a uniformed chart of general ledger accounts supported by a supply check list. The *Canadian Hospital Accounting Manual* is an attempt to produce on a national basis uniform financial statements. It is hoped that with the appropriate application of the procedure outlined in the *Manual*, administration will have financial figures that will stand comparison with another hospital of similar size and service. Thus, when efficiency is considered to exist in one hospital, comparison with others would point up the latters' deficiencies. By developing standards in this manner, it would be possible to measure efficiencies and assist administration in the task of achieving its goal of financial control.

Averages

The average figures usually associated with the hospital, such as the patient day cost, are not considered by some to be reliable financial information. However, as long as the reader recognizes the dangers inherent in using any average, a great deal of information on change may be garnered readily from ratios. Thus, if the per diems are developed in a consistent manner, they will show changes from such factors as price and quantity.

The most important quality in the average figure is that it is easily remembered and deviations are grasped at a glance. Another average figure of significance is that having to do with occupancy —the patient load.

Both the ratios cited here are examples of simple figures that may be used to advantage by administration as guides in the quest for efficiency—the result of effective financial control.

Internal Control

The term "internal control" refers to a means for safeguarding the resources of an organized entity by arranging staff work assignments so that each person

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Equipment

C. H. Kennedy

IT IS THE intention of the government of Nova Scotia to pay hospitals the cost of providing certain insured services to the residents of the province. But the term "cost" will be interpreted in accordance with the definition given by the federal government in the Hospital Insurance and Diagnostic Services Act. Cost is defined there, in Section 2(d) as follows:

"Cost means the cost, to be determined as prescribed in the regulations, of providing services in hospitals, but does not include (i) any amount expended on the capital cost of land, buildings or physical plant."

Cost, as here defined, does not include any amount expended on the capital cost of physical plant. Now we ask: "What constitutes physical plant?" Common accounting practice tends to place in the category of physical plant the actual building — that is foundations, floors, walls and roof—together with all equipment permanently affixed to the building. This would mean that boilers, elevators, plumbing and lighting lines and fixtures, and so on, would be classified as physical plant.

This means, then, that all movable equipment, including furnishings, is considered to be *other than* physical plant. As such it may be included in costs, and will be paid for by the commission.

In a hospital, there are some items of technical equipment which are permanently fixed, within the common interpretation of that expression. Perhaps the most outstanding single item in this category is an autoclave, which cannot by any stretch of the imagination be considered a piece of movable equipment. It was considered unfair that such equipment, so necessary in a hospital and so peculiar to its operation, should be excluded from costs of operation just because it operates in a fixed position instead of standing free, capable of being moved about and used in different locations.

Therefore, the strict interpretation of the term "physical plant" has been relaxed, so that certain items of technical equipment, even though fixed to the building, are considered as proper items of sharable cost. Some of these items of fixed equipment which are to be provided under the plan are: autoclaves, plaster sinks, special air conditioning for operating rooms, operating room lights, and physicians' in and out register. As part of the cost of providing insured services to residents of the province, then, all movable furnishings and equipment, and certain specified items of unmovable technical equipment will be provided.

It is very desirable to maintain high standards of service, and measures will be taken to encourage hospitals to provide a high quality of service. The provision of needed equipment is another factor in this phase of the hospital insurance plan. It has frequently happened in the past that hospitals have been prevented, through lack of funds, from having the quantity and quality of equipment that was required. This should no longer be the case, or at least, not to the same extent. Hospitals will be provided with the equipment necessary to let them maintain high standards in the services they provide.

The need for assistance to hospitals in the securing of proper equipment was recognized many years ago, and therefore, under the national health grants, hospitals have been supplied with equipment for laboratories, x-ray and rehabilitation departments, nurseries, paediatric and maternity units and others. As far as we know now, national health grants are being continued. There will, however, be no duplication of services between the grants program and the hospital insurance program. The rule will be that if any piece of equipment can be provided under hospital insurance it will not be provided through the grants. In other words, where a conflict exists between the hospital insurance program and the grants program, the hospital insurance program takes precedence.

Now what I have said does not mean that the commission will automatically pay for any equipment that the hospital may consider desirable. Far from it! There will be certain controls exercised by the commission over the purchase of equipment. These controls will certainly not discourage any hospital from securing equipment needed to provide adequate patient care. They will, however, be designed to ensure that there is no undue extravagance in the purchasing of equipment.

In the first place, hospitals will have to get approval from the commission for all purchases of equipment. Normally a hospital would submit a list of its expected equipment requirements along with its yearly budget estimates. This list would be examined by the commission, and some investigation would be made of the hospital's need for the items requested. In this investigation, the consultants would undoubtedly play a part, for they would have observed the equipment situation in the course of their visits to hospitals.

Having agreed that the hospital needs a certain piece of equipment, the commission would ask: "Is the particular item asked for the one best suited to the needs of this hospital?" Let us suppose that the hospital in Sheet Harbour is asking for approval to buy a 300 M A x-ray machine. The commission will certainly ask: "Does this hospital need a 300 M A x-ray machine? Are the staff members in such a small hospital going to be doing the kind of radiology that requires such elaborate equipment? Have they, or can they expect to secure the technical and professional staff qualified to make adequate use of such a machine?" If the answers to these questions are in the negative, the commission will probably rule somewhat as follows: "We agree that the x-ray machine in this hospital should be replaced, but we do not consider that this hospital's radiological requirements justify provision of a 300 M A machine. A 100 M A machine will serve their needs adequately, and we will approve purchase of the latter."

Again, it may be that the hospital needs a new incubator, but has not asked for it. Instead, they are asking for new furniture in the waiting room. The commission probably would approve the new furniture—if needed—only on condition that the incubator is provided first.

One may wonder whether a hospital is to be limited to requesting

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Mr. Kennedy is executive officer of the Nova Scotia Hospital Services Planning Commission.

H.O.M.

has a successful

SUMMER SESSION

On the left—Miss M. Hawkins, Mrs. L. R. Flight, Miss B. Riddell, and Miss R. M. Brown—and on the right—Sr. Laura Marie, Sr. M. Loyola, Miss M. L. Peart, and Mrs. D. Easter enjoy a U. of T. lunch.

THE 1958 summer session of the C.H.A.'s extension course in hospital organization and management was held at the University of Toronto from June 2 to 26. Over 130 students gathered here from Vancouver to Newfoundland, from as far north as Dawson City, and as far south as Texas, to attend a varied series of sessions, problem clinics and seminars.

The high enthusiasm of the group, despite the long hours—from 8.30 a.m. 'til 4.30 p.m.—kept them alert and eager even for the arduous evening sessions—seminars from 6 to 8 p.m. for the second year group, and problem clinics for the first year students.

Because of geographic factors and the large numbers participating in the H.O.M. winter course, it is not possible for regional groups to meet for lesson discussion. Thus, the summer session attempts to give, through lectures, material which would otherwise be difficult to present by correspondence during the winter. Various principles mentioned in the printed lessons are clarified, intensified, and further discussed, then, at this time. To do this, recognized men in the field of hospital administration lecture each summer to the groups.

This year, Dr. G. Harvey Agnew, professor of hospital administration, University of Toronto, lectured on hospital needs in the community, hospital ethics, and some facts about building and renovation. Norman D. Bailey, executive director of the Grant Hospital of Chicago, spent several days exploring the field of personnel and Malcolm G. Taylor, of the department of political economy, University of Toronto, with Dr. L. O. Bradley, Winnipeg General Hospital, further probed the many facets of organization and management, as well as health economics.

A curriculum change this year introduced a series of lectures on human relations, given by W. B. S. Trimble, director of the social science department of the Ryerson Institute of Technology, Toronto—a well received feature. Because of this response similar material will again be introduced in succeeding summer sessions.

A number of specialists from various hospital departments also contributed detailed, and in some cases technical, information about their work. Dr. Harold G. Pritzker, New Mount Sinai Hospital, Toronto, spoke on laboratories and pathology; George L. Riesz, also from New Mount Sinai, on outpatient and medical social services; John D. Griffin, who is executive secretary of the Canadian Mental Health Association, Toronto, spoke on mental health, and Ivan R. Griffiths, Queensway General Hospital, on pharmacy. Dr. R. Brian Holmes, Toronto General Hospital, informed the students about the radiology de-

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See groups page 52

A group of first year students chat between sessions: l. to r. are—E. M. Browning, S. R. Lamattina, W. L. Hilton, G. Burgess, Sister N. Ferguson, Dr. M. A. Deacon, L. E. Verret, Sister Saulnier, and G. A. Grose.

H.O.M. Second Year — 1958 Graduates

1st row, l to r.—Mary Mercer (staff) Sister André-Marie, Sister Allard, Sister Y. Aubert, Sister Justina, Sister M. Zita Rolheiser, Sister M. Laurentia, Sister G. Rideout, Sister Marthe-du-Sauveur, Sister M. Loyola, M. Hawkins, F. T. Seymour, Dr. P. E. Duval. **2nd row**—L. L. Wilson (staff), S/L N. M. Wallace, J. A. Innes, J. Simons, S. B. Pariso, H. J. Elliott, C. F. Matheson, J. C. Robertson, Sister G. Demers, Sister Marcellina, Mrs. L. R. Flight, Sister Laura Marie, M. C. Haw, E. W. Holborn. **3rd row**—A. C. Duncan, R. W. MacKenzie, G. Whittaker, G. W. Hanna, A. F. Smith, R. A. J. Krizanc, Miss M. L. Peart. **4th row**—W. A. O. Whitworth, R. L. Janisse, J. Matwichuk, W. E. Reynolds, D. E. J. Kelland, G. R. Wildblood, R. J. Mihalicz, Dr. C. Drolet. **5th row**—F. W. Hunnisett, B. A. Wolcyn, H. G. Gilhooly, Dr. F. McKerracher, T. R. Herd. **6th row**—S. R. Jones, W. B. Jones, C. R. Henderson, E. L. Dick, L. S. Wentzell, A. W. Kaytor, G. E. Cummings, W. Robb. **7th row**—P. E. Olivier, H. A. Lousley, Dr. E. R. Rafuse, F/Lt. H. M. Wright, F/O J. N. Tunney. **8th row.**—Lt. G. A. Slocomb, D. J. Bobbitt, F. D. Butler, R E. Trueman, C. E. H. Walden. (Missing from picture—A. R. C. Moores).

First Year Students

1st row. l. to r.—J. H. MacCallum, F. Whittaker, Miss B. Riddell, S. B. G. Simons, Sister Saulnier, Mrs. D. Easter, Sister Maria James, Sister Noella Ferguson, Sister John of the Passion, Sister Mary Clare, Sister Mary Francis, Sister Rita, Sister Margaret Marie, Sister Tougas, Sister M. Lourdes, Miss R. M. Brown, K. G. Muir, W. E. Powell, Dr. R. B. Goyette, Mary Mercer (staff). **2nd row**—Sister Ann Ell, Sister Dorothy Therese, Sister Helen Lavasseur, Sister Marie Albert, Sister M. St. Anthony, Sister Marie Alma Caruhal, Lt. A. W. Hood, H. T. Hart, K. B. Rutherford, H. A. Connolly, C. A. Cousins, L. L. Wilson (staff). **3rd row**—J. L. Pedden, Sister Cecilia Clermont, J. F. Cooper, E. H. Mills, J. T. Mulligan, J. O. Dale. **4th row**—Sister Patricia Ann, C. C. Christianson, Dr. M. C. Novak, J. J. Minguy. **5th row**— E. M. Browning, R. H. Procter, M. P. Hourigan, W. W. Devine, L. E. Verret. **6th row**—Lt. T. A. S. Kadey, B. W. Johnson, J. G. Lacoste, M. Stanton, H. M. Anderson, R. D. Beaman. **7th row**—G. Burgess, G. A. Grose, J. F. Retty, Col. K. J. Coates, M.D., S. R. Lamattina, N. Kilburg, A. J. Forkheim, Dr. M. A. Deacon. **8th row**—S. Worthington, W. L. Hilton, A. W. Holtby, J. Lysak, R. S. Rigg, E. Friesen.

How to Avoid

Medico-Legal Problems

Part II

Approved Hospital Bylaws are Law

Frederick Evis, M.D.,
Toronto, Ont.

THE bylaws of a hospital, when they have been approved by the lieutenant-governor-in-council, are, so far as the hospital for which they are approved, its staff and its patients are concerned, part of the statutory law of our province. It is the responsibility of the board of directors of each hospital to evolve bylaws which are applicable to the particular needs of its own hospital. At the same time, however, the bylaws should contain certain principles that have been found to be fundamental to the best patient care, to avoiding medico-legal problems, and to good hospital administration generally. For example, it is desirable for each hospital to have described in its bylaws some method which will be used in that hospital for the allocation of hospital privileges to the various members of the medical staff.

When carefully drawn, approved bylaws can be a very great help in avoiding medico-legal problems and law suits for a hospital board and the members of its staff. Therefore hospital bylaws are really important, and so we may justify outlining some simple fundamentals of hospital bylaw construction.

Four Fundamentals

Remember the Object of a Bylaw

A bylaw provision should either define and establish some term used, position created or form of organization (*e.g.*, a committee); or impose a duty or a responsibility; or grant a privilege. It should not preach a sermon, or deal vaguely with "ethics".

Avoid Ambiguity

Each provision in a set of bylaws should be clear, definite and specific in its wording and intention, so that suitable investigation can determine, if necessary, whether or not the requirements of a particular bylaw have been complied with in any special case. This is especially important with respect to medical staff bylaws, because a medical practitioner may be severely disciplined for failing to comply with the demands of a provision in the bylaws of the hospital in which he works.

Ambiguous, equivocal, or wishful phrases such as "it is expected that . . . ", or "it is hoped that the members will . . .", or "members should participate in . . . ", are not satisfactory for use in bylaws and should never be used. The verbs which should be employed are "shall" to impose a duty or responsibility, or "may" to grant a privilege.

Do Not Attempt to Include Anything in Bylaws by Reference Only.

No code of ethics can be incorporated, by means of reference only, into hospital bylaws in Ontario. The reason for this is that the lieutenant-governor-in-council cannot give approval, and thereby the force of law, to a set of provisions of which he does not have specific and detailed knowledge and which may be changed from time to time without his knowledge or consent by an organization over which he can have no control.

Furthermore, it should not be necessary to repeat in hospital bylaws ethical provisions to which professional personnel have committed themselves by their professional obligations.

However, if it is considered absolutely necessary to include any ethical provision in a set of bylaws, such provision must be set out fully and in detail for the consideration of the lieutenant-governor-in-council. But, remember that it is quite possible for a given ethical provision to be most desirable from the standpoint of the group which originated it, and yet at the same time for it to be contrary to public policy and therefore not suitable to receive the approval of the lieutenant-governor and thereby the force of law, so far as a public hospital is concerned.

For example, if the beliefs of the organization which operates a certain hospital forbid the use of tea, coffee and meat, these precepts should not be imposed upon members of different faiths who chance to be patients in that hospital and whose taxes, hospital insurance plan premiums, and perhaps voluntary donations, assisted in paying for the construction and contributed to the maintenance of the hospital.

Do Not State or Interpret in Bylaws Provisions from Statutes, Regulations or Common Law

It is neither necessary nor desirable to include in a hospital's bylaws any provisions which already exist in either The Public Hospitals Act or the regulations thereunder, or in any other piece of legislation. If such an inclusion were permitted, it is possible that at some future time the governing legislation might be amended in such a manner as to make adherence to the repealed provisions a breach of law. In such a case, if the hospital bylaw, which had been copied from the repealed legislation, were not promptly amended to bring it into accord with the amended legislation, it is possible that a member of the hospital staff, in faithfully following the bylaw with the best of intentions, might be misled into performing an illegal act, for which he, and the hospital board, might be held liable.

There is always a risk involved in the copying into hospital bylaws of statutory law from Acts or regulations, even if it is copied verbatim. Thus we see why, in Ontario at least, each set of hospital bylaws is intended to be complementary to, and to be read in conjunction with, The Public Hospitals Act and the regulations under the Act.

For somewhat similar reasons, no summary or interpretation of either statutory or common law should be attempted in hospital bylaws. The risk here is even greater. Invariably there is some-

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Frederick Evis, B.A., M.D., D.P.H., is a barrister and solicitor, and medico-legal consultant to the Ontario Hospital Services Commission. From a paper presented at the O.H.A. convention, October, 1957.

thing which is, or could be, misleading to the innocent reader when such abbreviations or interpretations are attempted. This is particularly true when the attempt is made by medical practitioners or members of a lay board, without the benefit of legal advice.

Instead, in each hospital, copies of The Public Hospitals Act and the regulations thereunder, and of any other legislation to which the hospital staff may have occasion to refer, should be kept easily available for the information and guidance of the administrator, the medical staff, the nursing staff and other hospital employees.

Here is one example of an attempt to state the common law which frequently appears in bylaws submitted for approval.

"It is called to the attention of the members of the medical staff that there is no legal sanction for the operation of sterilization in either male or female."

In the first place, this is not even a bylaw and could not be approved as such. It does not define or establish anything, it does not impose a duty, nor does it grant a privilege. But more than that, it is not even a correct statement of the common law. As such, it is worse than valueless because it is misleading. And yet, about six years ago this very bylaw, along with many other inadequate provisions, was recommended to hospitals by one of our prominent professional organizations. Needless to say, the bylaws which were suggested to hospitals by this organization, were drafted with the best of intentions, but without the benefit of legal advice.

This points up something which should be self-apparent. It is this: It is much cheaper in the long run, and will probably save considerable embarrassment, time and trouble, if hospital authorities would seek the opinion of the hospital's solicitor before doing anything which could have future legal implications. It is better to obtain advice in advance which will prevent medico-legal problems rather than to engage a counsel to settle them after they have arisen.

Approval of Hospital Bylaws

Quorum of Board of Directors

If a legal quorum of the board of directors is not present at a meeting, the transactions of the board at that meeting are illegal and can be challenged. The board should make sure that a legal quorum of the directors is present when bylaws or amendments to bylaws are passed. A majority of the board of directors normally constitutes a quorum. But a smaller number may be authorized as a quorum by the letters patent, supplementary letters patent, or by a bylaw or special resolution of the board. However, in no case shall a quorum be less than two-fifths of the board of directors.

Annual Election of Directors

The board should also make certain that the elected directors have been properly elected. Many hospitals wish to have directors elected for periods longer than a year. In view of this, I wish to draw your attention to a section of The Corporations Act, 1953, which provides that the election of elected directors must take place yearly and that all the directors must retire annually, but are eligible for re-election if qualified.

For the election of directors to be other than annually, the election time must be authorized by a bylaw which was passed before April 30, 1954.

Presenting Bylaws for Approval

Assuming that the board of directors has been legally constituted and that a quorum was present when the hospital bylaws were passed by the board, to obtain the required approval of the lieutenant-governor-in-council the procedure in Ontario which should be followed is this:

Three copies of the bylaws which have been passed by the board (administrative, or medical staff bylaws may be submitted separately, if desired) or three copies of any amendments which have been made to previously approved bylaws, as the case may be, should be sent to the Ontario Hospital Services Commission.

Each copy should have attached to it a certificate of enactment signed by the signing officers of the hospital corporation. This certificate should state that the copy to which it is attached is a certified true copy of the bylaws (or amendments) as passed by the board. It should also show that the bylaws (or amendments) have been confirmed by the general membership of the hospital corporation. Such confirmation is required for all bylaws, except for one whereby the board delegates its powers to a management committee. The certificate should also tell the dates when the bylaws (or amendments) were so passed and confirmed, and should bear the legal seal of the hospital corporation.

Comments on Common Law

Mentioned here will be just a few of the problems which have come to my attention in recent months and which appear to be of some importance to those interested in hospital operation.

Fee-Splitting

As an example of so-called ethical provision which has been spelled out in the bylaws of several hospitals is the one which prohibits the practice of dichotomy of fee, or fee-splitting. This is a practice in which a surgeon or other specialist secretly pays a part of the fee which he collects from a patient to the physician who referred the patient to him.

A fee-splitting prohibition in its most stringent and effective form was recently tested in the Ontario courts and approved as legal by the trial court and the Ontario Court of Appeal in the case of Henderson et al. v. Johnston et al (1956) Ontario Reports, 789. The Victoria Hospital in London, Ontario, adopted in its bylaws the so-called Columbus Plan to prohibit fee-splitting which contains a provision whereby all books of account of each physician and surgeon on the hospital staff must be open for inspection at any time, but not less frequently than once each calendar year, to an auditor appointed for the purpose by the board of trustees, or to such person or committee as the board may designate. The auditor is to report to the board indicating whether or not the physician or surgeon has complied with the provisions of the bylaw prohibiting fee-splitting. With respect to the surgical staff the board may authorize such further enquiries as may be deemed necessary.

The bylaw goes on: "if it is reported that such physician or surgeon has not complied with the provisions of this bylaw, the board of trustees may deny the privileges of attending patients in and/or the use of the facilities of Victoria Hospital to such physician or surgeon". The hospital bylaws were properly passed and confirmed, and received the approval of the lieutenant-governor-in-council which made them law.

Three physicians, all members of the medical staff of the hospital, sued the president of the medical staff and the board of trustees to have the medical staff

bylaws declared *ultra vires*, invalid and of no force or effect, with special reference to the Columbus Plan bylaw. The real objections of the plaintiff doctors, their counsel said, are to the terms of the bylaw which gives the board itself the right to deny them the privileges of attending patients in the hospital if it is found that they have contravened the provisions of the bylaw. The trial judge, Mr. Justice LeBel, whose judgment was sustained on appeal, said in part: "What it (the board) has done by the Columbus Plan bylaw is to say in effect to all members and prospective members of its medical staff, 'You will be entitled to the privilege of using the hospital, but the privilege is subject to two conditions, first, you must not split or divide fees, and second, you must permit our auditor to inspect your books so that we may make reasonably sure that you do not. Unless you agree to be bound by these conditions, you cannot be a member of our medical staff and you must forego such privileges and uses of the hospital as membership in that staff entails.' That is a positive action on the part of the board, certainly, but it is regulatory, not prohibitive.

"Unless the board can speak in that manner to the members of its medical staff it cannot govern, manage and control the hospital entrusted to its care, in my opinion . . . . It must have been felt that the new bylaw needed to have teeth in it. The members of the medical staff had to be disciplined where necessary or the evil could not be combatted. After all, and this fact must be emphasized, no one was, or is, required to seek appointment to the medical staff of Victoria Hospital.

"For the reasons stated I am satisfied that the Columbus Plan law is valid and binding upon the members of the medical staff of Victoria Hospital . . . and the general bylaws are also valid and binding.

"The question raised is whether medical men who secretly divide or split fees are guilty of conduct which is merely unethical under the code of ethics of the Canadian Medical Association, or more serious from a legal standpoint. I am satisfied that such conduct is considerably more serious."

Therefore we may say this: Fee-splitting can be made illegal in any hospital in Ontario by passing a bylaw prohibiting fee-splitting transactions and having the bylaw confirmed and then approved by the lieutenant-governor-in-council. And the bylaw can even go so far as to contain the Columbus Plan provisions for auditing the doctors' books of account.

Authority of Board of Directors

In the Alberta case of Andreas v. Edmonton Hospital Board (1944) 3 W.W.R. 599, (1944) 4 D.L.R. 747, the judge said:

"It is for the well-being of the patients and not for the benefit of doctors that the hospital is maintained. Full control of the hospital, given to the board, must surely include control over who may practise medicine and surgery in the hospital".

Also by Gordon v. Royal College of Dental Surgeons of Ontario, (1911) 23, O.L.R. 233, 18 CCC 224, and the cases cited therein the principle was well established that a statutory power to pass bylaws carried with it the implied power to impose reasonable penalties for their infraction; otherwise the bylaws would be largely nugatory. It is considered a "reasonable penalty" by our courts to deprive a medical practitioner of his membership on the medical staff of a hospital and of the privilege of attending patients in the hospital if he contravenes the provisions of a bylaw of that hospital.

It is well recognized that any hospital board has not only the authority but the responsibility to select its professional staff in such a manner as to assure itself, and so to assure those members of the public who may have occasion to use the hospital's facilities, that the doctors, nurses and other professional members of the hospital's staff to whom the board delegates hospital privileges, are well skilled and professionally competent and are willing to abide by the provisions of the hospital's bylaws and of other legislative enactments which govern the hospital and its staff. If a member of its professional staff proves himself to be of such a character that he avoids living up to the provisions that he agreed to accept to govern his professional conduct in his work in the hospital as a condition of obtaining medical staff membership and hospital privileges, then the board is legally and morally justified in discharging such an individual from its professional staff and in denying him any or all privileges in the hospital for a specified period of time, or forever.

Sterilization

Inquiries are frequently made concerning the legality of sexual sterilization done with the consent of the patient and the patient's spouse. It is basic that the consent of a patient, with or without the consent of the spouse,will never make an illegal operation (*e.g.*, a criminal abortion or an illegal sterilization) a legal one. Briefly, sexual sterilization may only be performed legally in Ontario for either of two purposes, viz; (a) to save the patient's life, or (b) to substantially benefit the patient's health.

In view of the seriousness of the implications of sterilization, the benefits to health should be substantial, as should the danger of death or serious invalidism from a future pregnancy, if that is the reason for the operation in a female patient. While the state of the common law (because of lack of court cases on the subject) is somewhat unsettled in Ontario with regard to sterilization operations performed for eugenic reasons, or for economic reasons it is highly probable, if and when a case does come to trial, that the courts will hold such operations illegal as being contrary to public policy.

In an American case it was held that a woman who agrees to an illegal abortion (and is therefore a party to a crime) cannot recover damages for negligence of the doctor who performed the operation—whether the action is based on tort or contract. (Nach v. Meyer, Idaho, 31 Pac, 2d 273). However, in Canada, sexual sterilization, while illegal, is not a crime because it is not defined as such in our criminal code. Therefore, here it is quite possible for a patient to give consent to a sterilization operation and then later change his or her mind and sue the surgeon who performed the operation and collect damages.

From what has been said it is obviously illegal to sterilize a healthy husband on the basis that his wife's poor health contra-indicates future pregnancies. If the wife's health is really bad, then she is the one who should be sterilized, because, for example, it is possible that the husband may be left a widower and may then wish to remarry and to have children.

In Murray v. McMurchy, (1949)

(Continued on page 86)

Chatting during a friendly coffee break are l. to r.: A. Bohnen, New Mount Sinai, Toronto; R. K. Travis, Hotel Dieu Hospital, Cornwall; W. F. Thompson, Peterborough Civic, Peterborough; Shaun Duffy, Toronto Western Hospital; and Fred Woodcock, Belleville General Hospital, Belleville.

First Eastern Workshop

J. Arthur Keddy
Toronto, Ont.

THE first Eastern Workshop, held as a joint effort of the Canadian Hospital Association and the Alumni Association of the C.H.A.'s extension course in hospital organization and management, marked a milestone for hospital educational programs when about 50 participants gathered at the University of Toronto from June 16 to 18 this year. Labour relations were discussed for the first two days, and nursing administration was under review on the final day.

Dr. John C. Sawatsky, associate professor of business administration at the University of Toronto, opened the first day's topic by describing the present context of labour unions as large, impersonal, industrial and urban. The worker, he said, is almost entirely dependent on his earnings, so he looks to greater earnings for his security and satisfactions. Dr. Sawatsky predicted that the growth of labour unions will continue, and will spread to a greater extent in the hospital field. He believes that, for management, this trend means (whether or not a union has been formed in the organization) good personnel policies such as an organization chart; job analysis; a wage structure that is internally consistent, but is also geared to community wage levels; careful placement and reassessment, so that the worker will feel he may have future opportunities; training in administration for workers, including nurses, who are being promoted to supervisory posts; and personnel appraisal, *i.e.*, keeping the worker informed of how you regard his services.

Opposition to a union sometimes discourages good employees from entering it, and thereby places control in the hands of a small and less responsible group. He did feel, however, that if untruths appear in handbills or other union advertising, the management should inform the workers of the facts. Dr. Sawatsky encouraged questions and so set a fine pattern for group participation throughout the sessions.

Management Approach

The management approach to labour relations was presented by R. V. Hicks, Q. C., of Miller, Thompson, Hicks and Sedgewick, Toronto. Mr. Hicks spoke from a wealth of experience in contract negotiations, and gave many helpful hints. There is often, he noted, a question of inclusion or exclusion of certain categories of employees, and he suggested an organization chart as a convenient decision basis in discussions with labour relations boards. He noted also the degree to which unions are seeking security, such as through union shop, closed shop, or check-off. Mr. Hicks stressed the importance of careful wording of agreements, and clear definitions, *e.g.*, *calendar* days or *working* days, not just days. He also suggested that senior management in hospitals should be available for outside reference and should not participate in the actual negotiations. Another suggestion was that, prior to negotiations, management should prepare its submission, and not simply wait for the submission to be made by the union. Contracts, he felt, should include a general clause about the rights of management, and should carefully spell out grievance procedures. In regard to personnel policy, Mr. Hicks made two very important points. First—a contract, once accepted, should be carefully explained to the supervisors in the hospital. They should be well informed as to the provisions in order to carry out the contract's terms properly and fairly. Second—there should be a written record of the warnings given to an employee, and when suspension is involved, the supervisor should record a statement at once.

On Monday evening Stan W.

Mr. Keddy is director of Medical records and statistics, Hospital for Sick Children, Toronto.

Martin, executive secretary-treasurer of the Ontario Hospital Association, and his administrative assistant, Harold Dillon, outlined the briefs presented by the O.H.A. to the provincial legislature's select committee on labour relations. Mr. Dillon also presented a case study of a labour dispute in an Ontario hospital. A report was given by Bern McCarthy, also an administrative assistant with the O.H.A., on his studies of the various contracts now in effect in hospitals of Ontario.

On Tuesday morning, June 17, William Dodge, vice-president of the Canadian Congress of Labour, began with a history of the labour movement, particularly in Canada, and outlined the organization of the congress, which includes departments of education, organization, public relations, international affairs, political education, research, and community affairs. As did the previous speakers, Mr. Dodge stated his views frankly and encouraged discussions. He felt that hospitals should accept the principle of collective bargaining, should cover their employees with unemployment insurance, and should ensure that their workers have satisfactory remuneration. Compulsory arbitration in the hospital field, the speaker believes, would not prove to be satisfactory.

In the afternoon Mr. Dodge joined a panel composed of David Archer, assistant to the president of the Ontario Federation of Labour; L. R. McCloskey, administrative assistant, Toronto General Hospital; and S. C. Nix, Beck Memorial Sanatorium, London. Mr. Archer favoured compulsory arbitration in the hospital field, and felt that in hospital contracts the procedures for settling grievances should be strengthened. The difference between hospitals and other employers was stressed by Mr. McCloskey, but he agreed with Mr. Hicks that personnel files should be fully documeted on discipline, suspension and dismissal. Many interesting discussions developed; Mr. Nix took the view that the *Rand formula*, by which dues are collected from non-members, is a violation of the democratic rights of an individual. Mr. Dodge countered by saying that once the union is certified it must bargain on behalf of all personnel in the categories which come under the agreement, and must even represent non-members in a grievance. No non-union employee ever refused the benefits gained by the union, he said!

By the end of the second day, thanks to the fine presentations made not only by the speakers and panel members, but by the group's members themselves, everyone was more aware of the various points of view in labour problems. This is an example of continuing education at its best, the very goal that the hospital association and the alumni had in mind.

(concluded on page 94)

Among Those Present

Front row, l. to r.: R. B. Ferguson, Humber Memorial Hospital, Weston, Ont.; Roy Copeland, South Peel Memorial, Cooksville, Ont.; B. Kent, director of nursing, Haldimand War Memorial Hospital, Dunnville, Ont.; Lois Anderson, Lady Minto Hospital, Cochrane, Ont. Four sisters are pictured here: Sister St. Maurice of St. Joseph's and Sister Mary Priscilla of Mount St. Joseph, both of Peterborough, Ont., and Sister M. Eugenie and Sister M. Frieda of St. Michael's, Toronto. Completing the row are Joy Parsons, Oakville-Trafalgar Memorial Hospital; L. L. Wilson, C.H.A. staff, and A. Roeder, Alexandra Hospital, Ingersoll, Ont.

Second row, l. to r.: Jean-Robert Parent, Sherbrooke Hospital, Sherbrooke, Que.; Noreen Flanagan, Medicine Hat Municipal Hospital, Medicine Hat, Alta.; Jack Orme, Haldimand War Memorial Hospital, Dunnville, Ont.; Fred Woodcock, Belleville General Hospital, Belleville, Ont.; Shaun Duffy, Toronto Western Hospital; Arthur Keddy, Hospital for Sick Children, Toronto; and Ella M. Howard, New Mount Sinai, Toronto.

Third row, l. to r.: John W. Brydges, Woodstock Hospital, Woodstock, Ont.; J. R. Donnell, Ste. Anne's Hospital, Ste. Anne de Bellevue, Que.; Sydney Anderson, Ottawa Civic Hospital, Ottawa, Ont.; A. J. Bohnen, New Mount Sinai, Toronto; George Thornton, Wellesley Division, Toronto General Hospital; and R. Carriere, National Health and Welfare.

Back row, l. to r.: R. Travis, Hotel Dieu, Cornwall, Ont.; Douglas Wickenden, Toronto East General Hospital; Boyd McAulay, Toronto Western Hospital; W. F. Thompson, Peterborough Civic Hospital, Peterborough, Ont.; and Bernie McCarthy, O.H.A.

MIND over MATTER

Part II

David Lander, M.D.,
Black Diamond, Alta.

FOR a long time it was thought that asthma, hay fever and migraine were entirely manifestations of allergy. I think that maybe allergy has been overdone. It is true, a lot of these people are allergic, but this doesn't explain all their complaints. There is no doubt that many attacks of asthma may be regarded as outbursts against personal insults—the person is literally "boiling" with rage, and when this rage overboils, it manifests itself as an attack of allergy.

A boy who worked in his father's fur shop developed asthma. The father had the diagnosis ready—"My boy is allergic to furs," he says; and he is right, according to the test. So the boy left Calgary and worked in Edmonton. Where?—back in a fur shop, but strange to relate, he didn't develop asthma. Why? If you had gone into his father's shop, and watched, you would have found the father a tyrant, always down the boy's neck. The asthma was a rebellion, an overboiling of rage. His is a common experience.

A child has a constantly running nose. Somebody says, "Aha, tonsils". He loses his tonsils and his nose still runs. So somebody says, "He's allergic"—and he is allergic to feathers. So everything in the house is covered with rubber, and still his nose runs. Actually what the child is doing is crying through his nose, rebelling against his lack of affection, and companionship. It has been said that "sorrows that are not vent in tears will make other organs weep."

Some of these children come from the very best homes—and the fathers in these homes all have something in common—they are bigamists; *i.e.* they are also married to their work. The treatment in these cases lies in going into the home and treating the parents.

There is no doubt that an intense, ungratified longing for love affects a person's allergic sensitivity. The mere fact that a mother bears a child does not mean that she loves it. Nor does the fact that she looks after it. Recently, an experiment was done on the connection between maternal rejection and allergy. It was found that the incidence of maternal rejection in an allergic group was four times as great as in a non-allergic group. The child can sense rejection and responds to it in some form of allergy. There is no doubt that a troubled mind or a fit of anger can actually spark a cold. Not for a moment am I saying that viruses and germs don't play a part, but when a person is emotionally upset, the lining of the nose becomes congested, forming a fertile place for germs to settle. One authority on psychosomatic medicine stated that half the clogged and running noses are the result of frustrating life situations. The treatment in these cases lies in treating the person, not his nose. Even in history, we find Prime Minister Gladstone speaking of a diplomatic cold. Whenever he had to face a tough adversary, he always was plagued with a cold.

Emotions also play a part in obesity or overweight. Years ago when an overweight patient went to the doctor he would say, "I know what the trouble is, doctor it's my glands." Now they come in and say, "It's my nerves, doctor." They are probably right because food may be used as a substitute for whatever is lacking in a person's life, especially love.

An unloved person says to himself, "Nobody loves me, so I'm going to be good to myself and gorge on food." A woman often buys a new hat for the same purpose. Very often overweight is used as a form of sex insurance. The fear of sex in some women is so great that they figure if they're overweight they will be left alone. It's not unusual, for example, when you tell an overweight's husband that she should lose about 40 pounds, for him to say, "Oh, no. I like her the way she is." Sure he does. He's afraid when she loses weight, when she looks attractive again, he might have competition.

The question is—why does an overweight eat so much? You might find that to some people the only pleasure in life is food—and you mustn't take it away from them because they can go into a depression, since every human being must love something to maintain his emotional equilibrium. One must be very careful in prescribing a diet; go into the emotional background of the patient and find out what it is that drives them to food.

Obstetrics and Gynaecology

The reproductive tract of the female is especially susceptible to influences of emotional change. Menstrual delay occurs in many instances and is especially common in single women who fear conception. There is no doubt that many abortions done behind closed doors are simply the scraping of uteri in which flow has stopped because of fear. It is true that menstrual

And why do you think Chamberlain carried an umbrella?

This is a frightful price but I don't approve of alcohol.

This is the second section of Dr. Lander's paper originally presented at the annual convention of the Associated Hospitals of Alberta, October, 1957.

pain, low back pain, irritability, menses, pain in the back, may be due to pelvic disease, but just as easily might be due to sexual incompatibility. A doctor at the Mayo Clinic has said that 75 per cent of pain in the female tummy is of emotional origin. I don't think there is any doubt that 50 per cent of gynaecological complaints are of emotional origin, and are merely psychosomatic manifestations sailing under the gynaecological flag.

There are other manifestations. For example, a common complaint in women is fatigue. Mrs. Jones comes to the office and says, "Oh, doctor, I have no pep. At ten o'clock in the morning I'm all pooped out." If you were to go into her home at ten o'clock in the morning you would find her sitting on the sofa, mop and broom in hand, listening to a soap opera describing a somewhat similar life situation. That woman may be very sick. Don't dismiss her complaints lightly. When you go into her history you will usually find the cause of the fatigue is a form of anxiety, an anxiety over rejection by a loved one, over other conditions in the home, over finances, and so on. I can recall a number of cases of fatigue in women in which the onset coincided with the discovery of infidelity in the husband. It was her way of saying, "I'll get even with you." But two wrongs don't make a right; such women can be helped by psychotherapy much more than by any number of prescribed tonics.

Emotions, too, are wrapped up in the "change of life" in women. For many years the unpleasant symptoms of the menopause were regarded as being entirely due to glandular difficulty. Now, however, we are changing our views. From time immemorial it was ingrained in the female child by her mother, grandmother, and aunt, that when she reaches the change of life she is going to suffer. When she reaches that stage she goes to great lengths to hunt out these symptoms. Then too there is the popular misconception that the change of life means the cessation of feminity. Actually many women don't begin to live until their change of life, for obvious reasons. Then, too, many well-meaning husbands, seeing their wives suffer, begin to leave them alone and the wife begins to wonder, "Who's he interested in now?" Then you have a vicious cycle.

Many of these women can be helped by being taught how to meet this crucial period of life. There is no doubt that the incidence of illness is much greater in the woman who is suffering from sexual maladjustment. We all know of the woman with a tendency to headaches; she has 222's in her handbag, a hot water bottle in bed. She is generally a frigid, unhappy woman. Frigidity is generally associated with a number of conditions such as backache, insomnia, moodiness, tension and anxiety. Often these women fall prey to surgery, but they can be helped by psychotherapy. Very often they are naggers, for nagging is generally a defensive mechanism—an attempt to ward off an attack before it can be made.

The Heart

The heart has been regarded as the seat of emotions, giving rise to such expressions as "hard-hearted", "broken-hearted", and "soft-hearted". In spite of the enormous incidence of heart trouble, most people who come to the doctor with heart complaints have really nothing wrong with their hearts. These people have a lot of anxiety in their make up. Often too it is the doctors who create anxiety. A patient comes in with a little pain about his heart; a slight murmur might be discovered; another doctor is called in to listen—who doesn't stop to talk to the patient—and first thing they know they have created a heart invalid. Almost every time somebody dies suddenly of a heart failure, two or three relatives will come complaining about pain around the heart.

It is not the situation alone that determines whether or not a person will develop a psychosomatic illness. The determining factor is how the person reacts to a situation. That is why it is so important to go into the patient's background, his education, his intellect, his religion.

Blood Pressure

"High blood pressure", a physician of Chicago has said, "is a disease of unhappiness and frustration. Don't send a high blood pressure patient away with only a dose of phenobarb. Sit down and talk to him, for the emotional lives of these people are filled with turmoil. If such people are helped early their blood pressure can be controlled."

I think our treatment of heart cases has to change. I remember as a student, listening to the professor expound on a case of heart trouble. To a married man of 50 he would say, "Now look, sir. You have a little heart trouble. You mustn't smoke. You wouldn't take a drink, of course . . . don't eat any salt, and leave meat alone." He would deny him other pleasures that are very dear to him. After the man left the office he would ask himself, "If I can't do this and this, what's the use of living?" Allow these people a moderate amount of all the things they like to do and they will live longer.

Migraine

Migraine headaches are affected by the change in the calibre of the blood vessels in the brain, and, of course, emotion has some influence on these blood vessels. Migraines seem to be more common on Monday mornings — could they be related to a reluctance to go to work? Many migraines are probably whippings of one's conscience for Saturday night excesses. A physician of the Mayo Clinic says that migraine is not a disease of the head, but a disease of the personality.

Arthritis and Rheumatism

When the delegates to the American Conference on Rheumatic Diseases met in New York 15 years ago, all they talked about was pulling teeth and removing tonsils. Last year when they met they talked about hormones and emotions. Probably about a third of the victims of sore joints have trouble which is essentially psychogenic, originating in the mind. These people have swollen joints and a rapid sed rate, but often they are also insecure, dependent people who deny their dependence. They have difficulty adjusting to change in a dog-eat-dog world, and they react to it violently. If the doctor doesn't remember that the chronic rheumatic often suffers from

chronic resentment, the patient is likely to lose his teeth, his tonsils and a few other organs. Often the real trouble is not a focal infection but a focal conflict—such as a domineering mother, a boss with a little-Ceasar complex, or a prodigal son.

Many of the sore backs we see are essentially emotional in origin. Many can be discovered in industry. These people generally have a chip on their shoulder; they are sure the boss is out to get them.

One chronic illness — down-in-the-mouth disease.

Emotional tensions can be discharged through the back with a terrific spasm which can throw the whole skeleton out of kilter. Injury and infection do affect cases of rheumatic disease, but hostility discharged through the muscles of the back can also produce an attack of arthritis. Watching a patient with a psychogenic sore back is like watching a pantomime. When he comes into the office he seems to be saying, "Oh, doctor, please help me. The load I carry is so heavy; the cross I carry is breaking my back." His physical symptoms are symbolic expressions of a desire to get out of an unpleasant life situation. If you look into his life situation you find that he is like a fish caught on a hook and struggling. For these people their backs act as a shield.

Colitis

Emotions also affect the bowels. People who suffer from colitis are often very proud and sensitive. To them love is just like food. Many attacks of colitis are preceded by an acute emotional storm about which the patient keeps on grieving; he cannot adjust himself to his loss. These people can be helped by the general practitioner if he will act as a crutch.

It's the decisions that make a day so tiring.

Consider as an example a mother and daughter living together. The daughter, about 35-40 years old, has made up her mind to be a career girl and live with her mother. Then one day her mother comes home and announces, "You know, dear, I'm getting married." The girl is out on a limb—and she develops colitis.

We have made enormous strides in medicine. The germs which used to cause most deaths we have practically conquered. But we are finding now that there is a more serious threat to man's health—not a germ but the man himself. We have many intricate instruments — electrocardiograms, x-rays, and so on—but none of these instruments can tell us when a man is dying of a broken heart. On the death certificate it may say that so-and-so died of colitis or asthma, but really in many cases, it was a broken heart. We must realize that the mind can be a source of pain. The patient who sits across from us at a consultation table may be sick because of faulty living, faulty thinking, or because of some great personal tragedy.

History is full of examples of psychosomatic medicine. Remember the story of Elizabeth Barrett. While she lived with her tyrannical father she was an invalid, bedridden for years. Yet when she met and married Robert Browning she became well practically overnight.

To use a very simple term, we could say that people suffering from psychosomatic illness have a "caught-in-a-trap" disease. Though caught in a situation they will not stop beating their heads against the bars of the cage. They have yet to develop the philosophy "if you can't remove it, you have to improve it."

Another term we could apply to their illness is stress disease. By stress I mean those everyday experiences that threaten the peace of mind, the aspirations and the self-respect of the individual. Anything which threatens one of these things can produce a psychosomatic illness. The slings and arrows of outrageous fortune can be just as effective in injuring an organ as real slings and arrows. An unkind word can inflict physical pain. These stress diseases are a product of our civilization. They are not suffered by educated people alone, but by any person who thinks.

Many a child will develop diarrhoea before an examination, for example, or a soldier breakdown before a battle, or a woman develop arthritis because of hostility toward her husband. These are all stress diseases. There is evidence now that diabetes in young people may be a stress disease. The clinics on Wall street report that when the stock market goes down, sugar in the urine goes up.

Let's go back to the nervous woman we see so often in the office. She is lonely and scared. She doesn't need scientific care as much as she needs the luxury of someone who will listen to her for an hour—not talk to her, but listen to her talk. It is not enough to treat the patient herself; you must relate her to her environment—her husband and her children. You may have to call in her religious advisor. The art of psychiatry doesn't consist in merely prescribing phenobarb and tranquillizers.

Tranquillizers are now used to lessen the nerve-jangling pain of living, but they can be dangerous. They interfere with our keenness and our powers of adaption. They remove anxiety, but actually a little anxiety is a good thing; if we weren't concerned about tomorrow, we wouldn't be careful on the highway today. In the American Air Force a man who has taken tranquillizers is grounded for 40 days. If people in slums took tranquillizers they would have no desire to improve themselves. These so-called "don't-give-a-damn" drugs do not change a situation. They only make us less aware of it. Tranquillizers must be used very carefully.

It's too bad that in our day and age people rely so much on drugs. Do you know that three out of every ten prescriptions now are for tranquillizers? Some time ago I happened to overhear two girls talking in a restaurant. One said to the other, "Mary, what are you going to do tonight?"

"I don't know," Mary answered, "I haven't made up my mind yet whether to take a benzadrine and go out, or a nembutal and go to bed."

(to be concluded next month)

23rd annual convention

Canadian Dietetic Association

THE magic sight of Niagara Falls by day, or illuminated by night, never ceases to enthrall. Possibly this was one of the reasons why the executive of the Canadian Dietetic Association chose the Sheraton-Brock Hotel, with its unequalled view of the majestic sight, for its 23rd annual convention, held from June 9 to 11, 1958. Four hundred and thirty-three dietitians from right across Canada gathered there for the three-day convention, making it the second largest registration to date.

The present membership in the Canadian Dietetic Association is 1,147 but, with increases in Canada's population and with increases in kitchen wings of hospitals and other institutions, the present demand for dietitians exceeds the supply. With this problem in mind, a panel discussion on "Dietetic Internship" was presented. It was chaired by Rachel Pilon, professional dietitian, Milk for Health, Inc., Montreal, and included three directors of dietetics — Eleanor Sortome, Royal Victoria Hospital, Montreal; Margaret Ketchen, Toronto General Hospital; Christina Robertson, Vancouver General Hospital—and the head of a home economics course, Dr. Margaret McCready, Macdonald Institute, Guelph, Ont.

The pros and cons of a proposed integrated intern course were discussed. One of its main objectives would be to interest home economics students, still at university, to enter the food service field by integrating summer under-graduate experience into established intern courses. The advantage to the student is that she would be ready to earn an adequate salary 18 to 20 weeks after starting post-graduate training. This would also be an advantage to food service institutions. A pilot study of the proposed integrated intern course is being experimented with in the Toronto area.

Annetta Turner, P. Dt.
Toronto, Ont.

Dr. I. M. Rabinowitch, M.D., F.R.C.P., well known for his studies of metabolism and particularly of diabetes, was guest speaker at the exhibitors' luncheon. His topic, "The Art of Scientific Discovery", proved to be a fascinating one. Dr. Rabinowitch tried to analyze the natural attributes of a person who is able to make discoveries of a very fundamental nature; for example, discovering insulin, the telephone, et cetera. He considered the following natural attributes as necessary — an insatiable curiosity, an alert mind constantly on the watch for the unexpected, the ability to choose the most promising when confronted with two or more alternatives, a peculiar form of stubbornness or persistence, the art of imagination, a wide range of interests, intuition, the ability to concentrate completely. But the first attribute, an insatiable curiosity, is the most important.

The Violet Ryley-Kathleen Jeffs Foundation Memorial Lecture is always one of the outstanding events of the convention. This year's guest speaker was Dr. Hilda Neatby, Ph. D., F.R.S.C., professor of history, University of Saskatchewan. In her address, "Education Through Fear or In Faith," Dr. Neatby traced some of the developments of basic concepts through the centuries which have led to our most modern philosophies of education.

Food Service

sponsored by the

Canadian Dietetic Association

Among a number of reports presented at the annual general meeting, the legislation committee reported that in six provinces Bills have been passed recently giving professional status to dietitians. These six provinces are Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba and Saskatchewan.

Officers

Persons elected to the executive of the Canadian Dietetic Association for the year 1958-59 are as follows: *President* — Diane Raymond, manager of restaurants, T. Eaton Company, Montreal, Que.; *President-elect* — Florence Silverlock, director of dietetics, Toronto Western Hospital, Toronto, Ont; *Vice-president*—Dr. Rachel Beaudoin, director, Institute of Dietetics and Nutrition, University of Montreal, Montreal, Que.; *Secretary*—Kathleen Gillespie, professional dietitian, Royal Edward Laurentian Hospital, Montreal, Que.; and *Treasurer*—Isabel Lockerbie, diet counsellor, Connaught Medical Laboratories, Toronto, Ont.

Physiotherapist, Dorothy Madgett, speaking at a noon luncheon meeting, said she would consider her talk on "Relaxation and Preventive Medicine" successful only if at its end most of her audience were nearly asleep. Miss Madgett explained that the emotional and physical aspects of tension were interdependent, and then proceeded to suggest ways of combatting tension. Thought control and constant reminders to relax are important in learning to combat tension. In the field of obstetrics, education and relaxation can lead to confident childbirth.

According to Dr. Charlotte Young, professor of medical nutrition, Cornell University, Ithaca, N.Y., presenting the topic, "Current Approach to Obesity", the surface has barely been scratched in this complex, intimate problem.

(concluded on page 90)

Annetta Turner is director of nutrition services at the Associated Milk Foundations of Canada, Toronto, Ont.

1956-57

Second row. l. to r.: Ghislaine Majeau; Guy Allard; and Yolande Taylor. In front is the staff: Leo Dorais, professor in human relations; Dr. Gerald LaSalle, director; Mother Jeanne Mance, R.H.S.J., assistant director; Albert Nantel, professor in business administration.

Hospital Administration Course at Montreal

THE university course in hospital management at the University of Montreal will begin its third year as of September. This course, established to meet the demand from hospitals, was made possible by a generous contribution from the W. K. Kellogg Foundation. It is the only university course of its kind in the world given in the French language.

The studies take two years—one year at school, and one year of training in a hospital. Thus, this first group of students are completing their year of training at the hospitals mentioned—Guy Allard, B.A., (Hôpital Sainte-Jeanne d'Arc), Ghislaine Majeau, M.A. (Hôpital Notre-Dame and Montreal General Hospital) and Yolande Taylor, B.A. (Royal Victoria Hospital).

This training year is placed under the direct responsibility of the hospital administrator who agrees to participate in university education. Another group, larger than the first, is now being sent to the following hospitals: Royal Victoria Hospital (Gilbert Blain, M.D.); Hôpital Saint-Luc (Wilfrid Blanchard, C.A.); Hôpital Saint-Boniface, Man. (Sister Lucille Gosselin, s.g.m.); Hôpital Notre-Dame (Gaston Leduc, M.D.); Hôpital Sainte-Justine (J.-Thomas Pogany, L.L.D.); and the St. Vincent Hospital, Worcester, Mass. (Sister Thérèse Trottier, r.h.s.j.).

The course is directed by Gérald LaSalle, M.D., D.H.A. (Toronto), and Mother Jeanne Mance, r.h.s.j., D.H.A. (Toronto). Inquiries should be directed to the Higher Institute of Hospital Management.

* * * *

LE COURS universitaire d'administration hospitalière inaugurera en septembre prochain sa troisième année d'enseignement. C'est en réponse à la demande des hôpitaux que l'Université de Montréal a créé ces cours grâce à la contribution généreuse de la Fondation W. K. Kellogg. Il s'agit de la seule école universitaire de langue française au monde où se donne un tel enseignement.

Les études durent deux ans: une année académique et une année de résidence dans un hôpital. Ainsi, le premier groupe d'étudiants termine, aux hôpitaux mentionnés leur année de résidence; il s'agit de M. Guy Allard B.A. (Hôpital Sainte-Jeanne-d'Arc), Mlle Ghislaine Majeau, M.A. (Hôpital Notre-Dame et Montreal General Hospital) et Mme Yolande Taylor, B.A., (Royal Victoria Hospital).

Cette année de résidence est sous la responsabilité immédiate de l'administrateur de l'hôpital, lequel accepte de participer ainsi à l'enseignement universitaire. Un nouveau groupe, plus nombreux que le précédent, se dirige maintenant vers les hôpitaux suivants: Royal Victoria Hospital (M. Gilbert Blain, M.D.); Hôpital Saint-Luc (M. Wilfrid Blanchard, C.A.); Hôpital Saint-Boniface, Man. (Soeur Lucille Gossselin s.g.m.); Hôpital Notre-Dame (M. Gaston Leduc, M.D.); Hôpital Sainte-Justine (M. J.-Thomas Pogany, L.L.D.); et le St. Vincent Hospital, Worcester, Mass. (Soeur Thérèse Trottier, r.h.s.j.).

(concluded on page 102)

1957-58

Second row l. to r.: J. Thomas Pogany, L.L.D.; Gaston Leduc, M.D.; Sr. Thérèse Trottier, R.H.S.J.; Sr. Lucille Gosselin, s.g.m.; Gilbert Blain, M.D.; and Wilfrid Blanchard, C.A. Front row are members of the staff.

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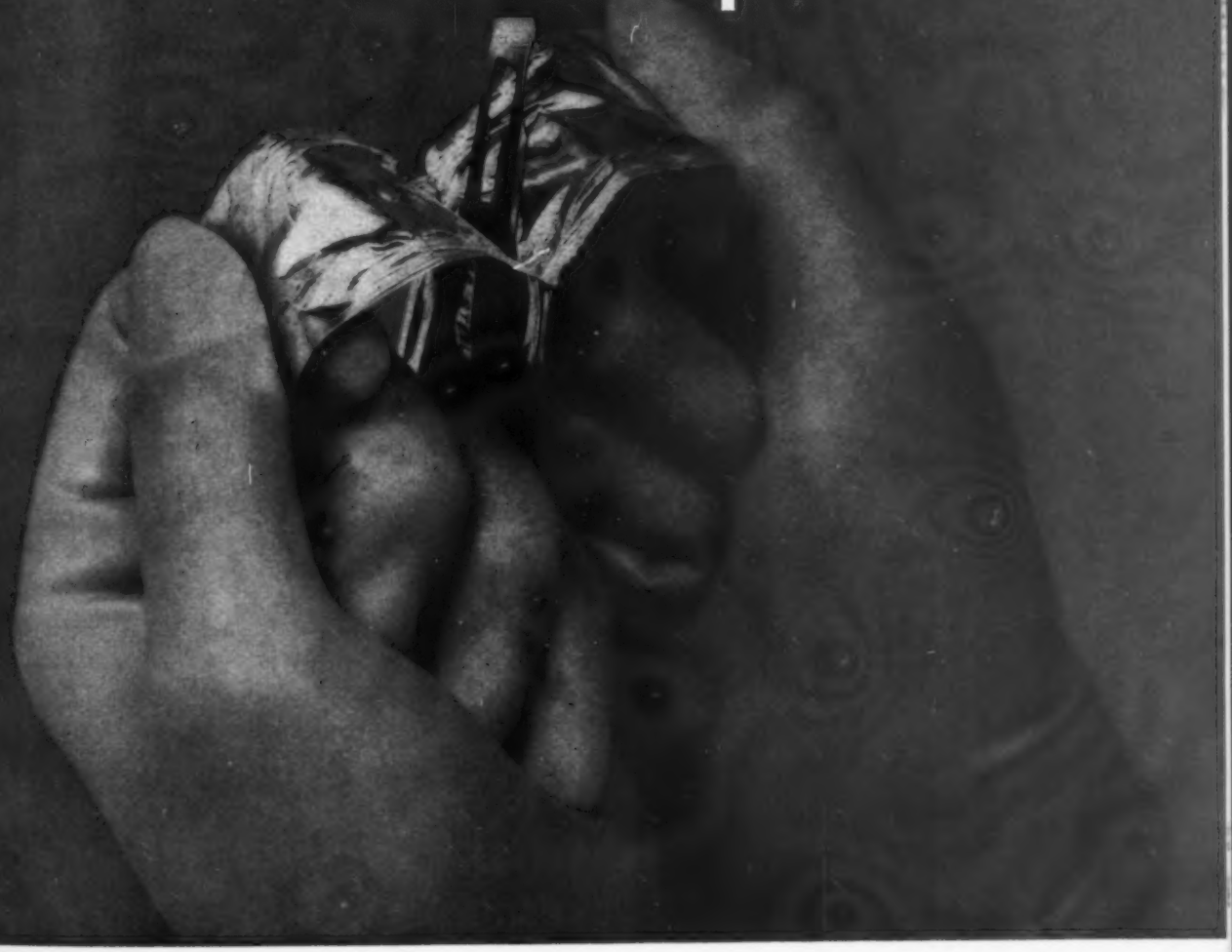

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With the Auxiliaries

B. C. Centennial Capers

The past came to the present in British Columbia recently by means of the centennial celebrations held there. The Ocean Falls General Hospital's auxiliary "went native" and gave residents a chance to see Indian art, customs and dances of the type which dominated Canada's western coast many years ago.

The ladies of Chemainus General Hospital held a full day celebration. Highlighting the proceedings was a fashion parade of period costumes — all authentic. There was even a shawl worn by Queen Victoria. Their centennial project is the sale of "hastinotes", decorated with a picture of early Chemainus and the centennial crest.

Chilliwack United Church, chosen for the Chilliwack General Hospital auxiliary's spring tea, contained a teepee and campfire set up against an evergreen background. Guests wearing gowns fashionable 100 years ago were served by hostesses dressed in clothes of the same period. Murals depicting historical events and places of local interest added still more colour.

Taggers—English and French

An annual appeal for funds, held by the two ladies' auxiliaries of Youville Hospital, Noranda, Quebec, culminated in an enthusiastic tag day. Whether English or French, citizens were "tagged", since both auxiliaries were out in full force, the French in Rouyn and the English in Noranda. The ladies wish to add to the impressive list of equipment they have provided already for the hospital.

News from Manitoba

An interesting program is being planned for the September convention of Manitoba's auxiliaries. A four year plan of decoration is to be begun. Twenty-one auxiliaries will be requested to provide either a table centre showing one of their best projects or a group of unusual tray favours used during the year. Prizes will be given for the best contributions. To encourage members to visit the exhibits, printed name cards will be available at each booth. Whoever collects the largest number will receive a free luncheon ticket. To help auxiliary members make as many new friends as possible during the convention, a coffee break (really a "get acquainted" party) is to be held on the first morning.

One of these Manitoba auxiliaries, the McKinnon Guild of the Children's Hospital, Winnipeg, showed a flair for originality by holding a colourful "Patio Party". Huge garden umbrellas, attractive patio cards, and models in lovely summer cottons provided a charming background for the luncheon.

And So . . . They Sew

New curtains for every ward in Reddy Memorial Hospital, Montreal, Que., was the aim of the sewing group of the women's auxiliary. After taking drapemaking lessons, which were donated, the women spent two afternoons a week at their project, working assembly-line style. In a short time, the sewers have turned yards of material into fully lined, double-width draperies.

Garden Gambols

The annual garden party staged by the ladies of the Grace Hospital auxiliary, Windsor, Ont., provided all the fun of a circus in a garden close to home. Children rode ponies, sought treasures in the fish pond and even had their own tea room. Adults visited the treasure booth, the handicraft booth, or had their futures read in the stars. Everyone enjoyed those festive treats that are so much a part of every fair—balloons, popcorn and candy.

The specialty of the party was the pick-up delicatessen. Guests could order delicious dinners at the hospital a few weeks before the party. Then everyone picked up his choice — roast chicken, turkey pie, ham, salads, blueberry muffins, apple tart, et cetera. There was food and fun for everyone.

Art Show

Local artists were given a chance to display their work in Haney, B.C., when the Maple Ridge Hospital Auxiliary sponsored a spring art show. The paintings, which lined the walls, showed rugged, snow-capped mountains, stormy seas and placid lakes, as well as brightly-hued flowers, lifelike portraits, and charming country homes and scenes. Also presented were a number of photographic studies, and some colourful shell pictures. Ceramic objects (many of them made from Haney clay) added to the colour, while a collection of articles fashioned from driftwood made an eye-catching display.

Lunches served by the auxiliary members, and music from piano and violin made the show complete.

Come to the Fair

The grounds of Grace Maternity Hospital, Halifax, N.S., provided a colourful setting for the annual fair held by the women's auxiliary. A flower table displayed potted plants and fresh blossoms; a country store showed tempting canned goods and preserves. There was also a grab bag table, an apron and hand work table and a white elephant table. The youngsters were given the chance to have some fun in a playground on the grounds, while their mothers toured the various exhibits to the lively music of the navy band.

The fair, opened by the wife of Nova Scotia's lieutenant-governor, was a great success. The auxiliary plans to use the money obtained through the festivities to purchase 12 more nursery units for the hospital.

Children's Chums

The children at Sarnia General Hospital, Sarnia, Ont., have their surroundings brightened and their days made more pleasant through the efforts of the children's ward auxiliary. Every afternoon, one of the "story ladies" (not always an auxiliary member) arrives to spend two hours with the children, reading, playing or talking.

A new and interesting fundraising project—the photographing of newborn infants—is also being carried on by the auxiliary members. The pictures are taken

(concluded on page 102)

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Equipment

(concluded from page 50)

equipment at budget time once a year. Must they do without unless they foresee their needs 12 to 15 months in advance? Probably not, although they will be encouraged to look ahead and make their requests as fully as possible along with their operating budgets. However in cases of real need, especially if occasioned by unexpected failure of the equipment, purchases could probably be approved even if not made at the proper time.

The method by which the commission will pay for equipment is to be that of depreciation, and not that of outright purchase. The federal plan will permit provinces to pay for equipment in one of two ways, with the provision that, in general, the method selected by the provincial authority must be uniform for all hospitals in the province. These two methods have come to be known as (1) outright purchase and (2) depreciation. Under the outright purchase method, the commission would pay the hospital immediately and in full for each piece of equipment as the hospital bought it. The method of depreciation is just what its name implies. The hospital will buy the equipment in the first place, but over a period of years the commission will repay the hospital through an annual allowance for depreciation. The second method, that of depreciation, will apply in Nova Scotia.

How is the depreciation to be calculated? There are several methods of applying depreciation, and I can say unequivocally that we are going to stick to the straight line method—the simplest for all concerned. This, as the accountants know, is the method by which a fixed percentage of the cost of the price of equipment is charged off each year. Thus an item that costs $100 and had an expected useful life of ten years would be depreciated at the rate of ten per cent per year, so that at the end of the ten years no value would remain in the books against this item.

The biggest problem in this regard is concerned with the equipment in hospitals at the inception of the plan on January 1 next. It will be necessary to know the original cost of this equipment and the date of purchase, so that the depreciated value at the beginning of the plan may be established and the proper depreciation allowed during the balance of the life of this equipment.

Frankly, we are not sure how big a problem we are facing in this regard. Perhaps all hospitals in Nova Scotia have accurate, up-to-date, plant ledgers in which the necessary information is already recorded. But I doubt that this is the case. Some have such ledgers, but some, I am afraid, have none. Those who do not have such records available will have to dig out the information, so that a proper basis for the calculation of depreciation may be established. If other hospital records do not even provide the basic date from which to work, then some other method will have to be applied. Appraisal by a qualified person or team is one way of approaching the problem. Another would be to accept the figures shown on audited balance sheets over a period of 15 to 20 years, and work from these totals rather than from individual items. Under this last scheme, an over-all life expectancy of 16 years, as suggested by CHAM, might be accepted, and the purchased value of equipment on the balance sheet at December 31, 1943 (15 years ago) would be depreciated for only 1 year, that for 1944 for 2 years, and so on. Which scheme will be followed has not been decided at this time. Of course, purchases subsequent to January 1, 1959 will present no problem. These will be matters of record in the hospital accounts, and such records will be kept very carefully from now on. They will mean money in hospital bank accounts.

I am sorry to say that there is no decision at present on the subject of method of paying the depreciation to the hospital. Two suggestions have been made, and we must make up our minds between them. Either the depreciation allowance can be paid to each hospital as a separate payment, or the depreciation can be included with other costs in the fixed portion of the budget and be paid indirectly as part of periodic lump sum payments. Of course the hospital will have only a minor interest in the method of payment, for in the course of the year, by either method, the amount the hospital will receive on account of depreciation will be the same.

That, in rather broad outline, is the commission's plan for providing equipment to hospitals. Some questions I have been unable to answer because decisions have yet to be made.

Western Canada Institute Planned

Winnipeg, Manitoba, will be the scene of the Western Canada Institute, to be held September 15 to 19 this year. The topics slated for discussion provide a wide range of helpful information for hospital representatives.

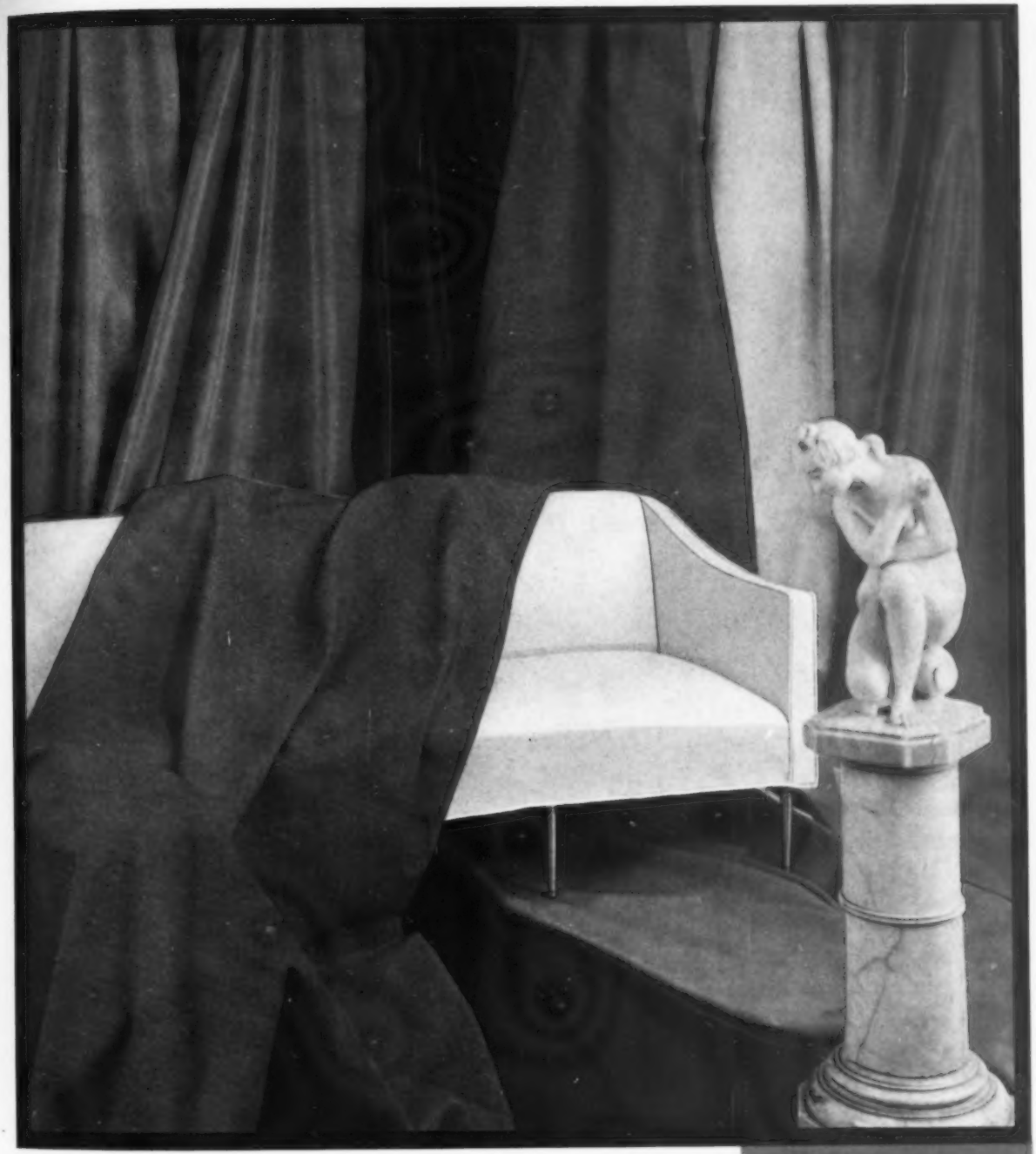
The institute will open Monday morning with a "keynote" address, which will be followed in the afternoon by two periods; one devoted to "The Future Demand on Hospital Services", and the other, an extension of the first, carried out with representatives of medical, administrative, trustee, and consumer groups.

On Tuesday, the first session is planned as a demonstration of the federal government kit on disaster planning. This demonstration will be followed by "Disaster Programming", as outlined by a representative of the American Hospital Association. The afternoon will be turned over to a program on trustee problems and relationships with the hospital and the community.

"Aseptics in Hospitals" will be Wednesday's subject, with a general panel discussion in the morning, and a visual session of the field's newer techniques and equipment in the afternoon. The next morning, speakers will discuss: linen (use and abuse), housekeeping, central supply room, and personnel problems; then there will be small display groups, or smaller meetings to talk over the various problems connected with these particular services. Thursday afternoon, a demonstration group from the Dale Carnegie Institute will present "'Four Keys' to Better Leadership".

The last day—Friday—will, in the morning, be devoted to "Building your Staff for Tomorrow", a topic dealing with in-service training and development. In the afternoon, the institute will end with a business session of the Associated Hospitals of Manitoba.

This year the Western Canada Institute for Hospital Administrators and Trustees will be combined with Manitoba's fall hospital and nursing conference in which 11 organizations will participate. The Manitoba branch of the Canadian Physiotherapy Association is the latest group to join the conference.



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22nd annual convention

THE C.S.L.T. REPORTS

OVER 300 delegates registered at the Canadian Society of Laboratory Technologists' 22nd annual convention, held from June 8 to 12 at the King Edward Hotel in Toronto, Ont. C.S.L.T. members look forward to these meetings with considerable enthusiasm, for they mean meeting both old and new acquaintances, as well as hearing scientific papers and seeing demonstrations of the most recent advances in medical laboratory science. This year's convention was no exception as delegates enjoyed a wide variety of scientific papers and an entertaining social program. Seventeen scientific equipment and drug houses had exhibits which were viewed with interest.

The convention got off to a flying start on Sunday afternoon when delegates went on a bus tour of Toronto to have a brief look at North America's most rapidly growing city. On Sunday evening, a coffee party, courtesy of the Baxter Laboratories of Canada Ltd., was held to enable members and guests to mingle and meet. On Monday morning, Harold Amy, president of the C.S.L.T. presided over the opening ceremony, and those bringing greetings to the convention included the Mayor of Toronto, Nathan Phillips, and Lorne Whitaker, M.D., president of the Ontario Medical Association.

The keynote speaker of the convention was Garnet T. Page, M.D., deputy general secretary of the Engineering Institute of Canada, whose topic was "Education—the key to Canada's future". Dr. Page stressed the importance of training in modern day technology.

The topics for the Monday scientific sessions included papers on bacteriology, blood banking, chemistry, and a film directed and narrated by Dr. Hans Selye of Montreal, entitled "Stress and the adaption syndrome". Dr. D. M. Young, director of laboratories, Toronto General Hospital, in his talk on the organization and administration of the hospital laboratory, pointed out that laboratories are an integral part of the hospital organization. It is essential, he said, that laboratory personnel willingly co-operate with other hospital departments in ensuring that patients receive the best possible care. All the scientific sessions were well attended and much credit must go to Miss Ellement of Niagara Falls, Ont., for arranging a well balanced, diversified and interesting program.

Speakers from other countries included Dr. Ralph Gander, director of the microscopic research department, Wild Heerbrugg Ltd., Heerbrugg, Switzerland, who spoke on "Scientific Microphotography and Microcinematography", and Jack Causton, charge technologist of the Tuberculosis and Mycology Laboratories, Johns Hopkins Hospital, Baltimore, Md., U.S.A., who spoke on "Antibiotic serum levels in patients with M. Tuberculosis".

The annual business meeting of the C.S.L.T. occupied members all day Wednesday, and some lively discussions concerning Society policy and technologists' welfare ensued. At this meeting, the election of officers for 1959 took place, and Jessie Hudson, Vancouver, B.C., was chosen as president-elect.

A banquet, held on Wednesday evening, was attended by over 200 of the delegates and guests. The guest speaker, Dr. N. S. Grace of the Dunlop Rubber Co., gave an interesting talk on what goes on behind the scenes in rubber and plastic research.

Thursday's scientific program included a round table panel discussion, which provoked considerable interest among delegates. The panel members answered questions on laboratory technique and procedures in all phases of medical technology.

The five days of convention were ended by a visit to the laboratories of the Ortho Pharmaceutical (Canada) Ltd., a visit which was both entertaining and enlightening.—*Ileen Kemp, executive secretary of the C.S.L.T.*

Coming Conventions

Aug. 16-18—American College of Hospital Administrators, annual meeting, Chicago, Ill.

Aug. 17—The 24th annual convocation of the American College of Hospital Administrators, Orchestra Hall, Chicago, Ill.

Aug. 18-21—American Hospital Association, annual convention, International Amphitheatre and Palmer House, Chicago, Ill.

Aug. 23—Interim meeting of the American Institute of Ultrasonics in Medicine, Bellevue-Stratford Hotel, Philadelphia, Pa.

Sept. 2-12—The 26th Chicago Institute for Hospital Administrators, conducted by the American College of Hospital Administrators, International House, Chicago, Ill.

Sept. 15-18—Canadian Association of Medical Record Librarians, 24th annual convention, Quebec City, Que.

Sept. 15-19—Western Institute for Hospital Administrators and Trustees, Royal Alexandra Hotel, Winnipeg, Man.

Sept. 24-25—Catholic Hospital Conference of Alberta, annual meeting, Edmonton, Alta.

Oct. 15-17—The Saskatchewan Hospital Association, annual meeting and institute, Bessborough Hotel, Saskatoon, Sask.

Oct. 18-19—The Catholic Hospital Conference of Saskatchewan, annual convention, Saskatoon, Sask.

Oct. 21-23—Annual convention of the Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alta.

Oct. 26-27—Catholic Conference of British Columbia, annual meeting, St. Paul's Auditorium, Vancouver, B.C.

Oct. 27-29—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 28-31—Annual convention of the B.C. Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Notes on Federal Grants

Construction

The Royal Columbian Hospital, New Westminster, B.C., has been awarded more than $137,000 by the federal government. This will go towards the cost of constructing a new nurses' residence. The new building will contain 204 beds and be constructed of reinforced concrete, with terrazzo floors throughout. Alterations and improvements are also being made in the main nurses' residence, The McAllister Home.

A grant of $499,000 has been made to help meet costs of a new Institut de Rehabilitation in Montreal, Que. The brick and concrete building is to provide accommodation for 111 patients and for 16 nurses. Included will be consultation and treatment rooms, physiotherapy, occupational therapy and orthophonic departments, a prosthetic workshop and other up-to-date services.

Financial assistance of $21,500 has been granted by the federal government to the Gull Lake Union Hospital, Gull Lake, Sask. This money will go towards the construction of an 18-bed hospital, including six bassinets and a community health centre. The new building, of frame with brick exterior and terrazzo finished floors, is to replace one no longer suited to be a hospital, and is expected to be completed early in 1959.

Diagnostic and Research

Hôtel-Dieu, Sherbrooke, Que., is to receive a cancer control grant of $34,280 for the purchase of equipment to improve the diagnosis and treatment of cancer in the clinic of the hospital. The Hôtel-Dieu's cancer clinic, operating since 1955, last year treated 186 cases.

Also to receive a cancer control grant is the new Sacred Heart Hospital in Hull, Que. More than $24,800 has been allotted to establish a cancer clinic in this 400-bed hospital to form an educational centre for cancer control, as well as a treatment centre for patients. The money will assist with the purchase of x-ray equipment.

A glaucoma clinic at Notre-Dame Hospital, Montreal, Que., will be established with the help of a $21,252 grant. This is the third glaucoma clinic to be set up in Montreal with federal assistance, one having been at Montreal General Hospital in 1950-51, and one at the Hôpital Hôtel-Dieu the following year.

Under provisions of the national health grants program more than $14,900 has been awarded to the Regional Laboratory at Campbellton, N.B. The funds will help purchase necessary equipment for the new laboratory, which is part of New Brunswick's plan to extend services to the northern part of the province.

Federal assistance of $28,287.55 will go to Ste-Justine Hospital, Montreal, Que., for the purchase of radiological equipment to be used in the diagnosis of cardiac diseases. The equipment will be placed in the hospital's recently established cardiology centre.

Public Health

Funds, totalling more than $17,500, will be used for additional public health services provided by the London (Ont.) City Health Department. This assistance will include salaries of extra staff as well as the purchase of equipment for clinics.

Mental Health

McMaster University, Hamilton, Ont., in the process of building up a department of psychology, will receive a grant of more than $9,800 to aid in extending this program to include post-graduate training in clinical psychology through the addition of an assistant professor and a technical assistant to the present staff.

A grant of $18,700 will be used towards the salaries of additional full and part-time personnel augmenting the staff of the Ontario Hospital in North Bay, Ont. A full-time specialist and other consultants will now be on the staff.

Nursing Care Survey

A survey during a 64 week period has been made in the Winnipeg Municipal Hospitals on the number of hours of care provided on each ward per patient, each 24 hours. On the chronically ill wards patients receive on the average 4.19 hours each of nursing care; with 1.51 hours given by registered and licensed practical nurses, and 2.68 given by nurses' aides and orderlies.

The hours of care on the poliomyelitis wards have been considerably higher than on the chronically ill wards. On ward B, where considerable detailed and emergency care is still required five years after many of the patients were admitted, the care has averaged 11.24 hours per patient each 24 hours, with 4.18 of these hours given by trained personnel. On ward F, also poliomyelitis patients, the average hours of care provided have been 7.52, with 2.83 hours from trained personnel.

Ward E, originally a poliomyelitis ward, then for chronically ill patients, now is a rehabilitation ward. Because of the changes made in the type of patients, its hours of care over the survey period are somewhat higher than they are at present. Over the entire period they averaged 5.29 hours of care, with 1.88 hours given by trained personnel.—*The Beacon.*

Speedy Rehabilitation

A plan to speed the rehabilitation of disabled persons recently inaugurated in Lethbridge hospitals has been reported by L. R. Gue, Provincial Co-ordinator of Rehabilitation for Alberta.

When hospital authorities feel that rehabilitation will be required, a special form, which doctors have been asked to complete, is attached to the patient's chart. That form, when brought to the attention of the Rehabilitation Committee, sets it to work promptly at getting the patient ready to return to normal community life. Since rehabilitation is much easier when the patient is contacted quickly, this is an encouraging step, one that might be adopted with necessary modifications by all Canadian hospitals.—*The Labour Gazette.*

Suggestion for a hospital accident prevention poster: Don't get hurt. We are here to take care of accidents; not to produce them. —*The Canadian Nurse.*

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Table 2C

Personnel—Diagnostic Radiology

Actual January, 1958—Estimated Requirements, 1959 and 1965

Hospitalization Plan—Nova Scotia

Region	Registered X-Ray Technicians			Other X-Ray Technicians (1)			Professional (2)		
	Jan. 1958	1959	1965	Jan. 1958	1959	1965	Jan. 1958	1959	1965
Cape Breton	11½	21	26	0	1½c	1½c	2	4	6
Eastern	2	3	4	0	1½c	1½c	1	1	1
Pictou	5	4	5	0	0	0	0(3)	1	1
Cobequid	3	3	4	0	1c	1c	1	1	1
Cumberland	3	3	5	0	1½c	1½c	1(4)	1	1
Fundy	4	8	10	4	0	0	1(5)	1	2
Western	3	5	9	1	0	0	1(5)	1	1
Southern	1	3	7	2	0	0	¼	1	1
Atlantic	19	24	32	4	4+½c	5+½c	5	8	11
Total	49½	74	102	11	4+6C	5+6C	12¼	19	25

(1) Includes combined technicians and technicians without formal training.
—"C" indicates combined technician.

(2) Radiologists

(3) Position to be filled in immediate future.

(4) Radiologist leaving for further training on February 1, 1958.

(5) Armed Service Radiologist doing some work in area.

Personnel

(continued from page 46)

Good hospital and medical practice recognizes that total rehabilitation of the patient is the desirable goal. Moreover, rehabilitation may be said to start as soon as the patient becomes incapacitated; in other words, rehabilitation should be carried out as a part of the treatment in both the active and chronic phases of illness or disability.

There are now 11 physiotherapists in the hospitals of Nova Scotia, excluding D.V.A. service hospitals and tuberculosis institutions. Of these 11, four are with the Rehabilitation Centre in Halifax. The Victoria General and the City of Sydney Hospitals are the only general hospitals with physiotherapists. It was stated in the brief of the Nova Scotia Rehabilitation Council that it is impossible, without extensive study and research, to give any firm estimate of the number of physiotherapists required under a hospital insurance plan. One of the difficulties is the lack of adequate supervision, since a physiotherapist should function under the competent direction of a physiatrist. In the United States, it is recommended that in every hospital of 500 beds or over there should be a physiatrist. Although it is impossible to estimate with any accuracy the probable need for physiotherapists, it can be said that a very substantial increase in the number of such personnel is indicated. For example, the Rehabilitation Centre in Halifax now requires three additional physiotherapists, and any significant expansion of the Victoria General Hospital will call for an increased staff. The regional hospitals, at least, will need to have physiotherapy services for both acute and chronic patients.

In Canada at present only four schools offer courses in physiotherapy—at the universities of Alberta, Toronto, Montreal and McGill. In each case these schools are administered by the faculty of medicine.

The Department of Public Health has awarded bursaries to a total of 14 trainees since 1954; four of these students will graduate in 1958, two in 1959 and one in 1960. It is expected that further bursary awards will be made later this year. It is possible that Dalhousie University may see fit to set up a school for physiother-

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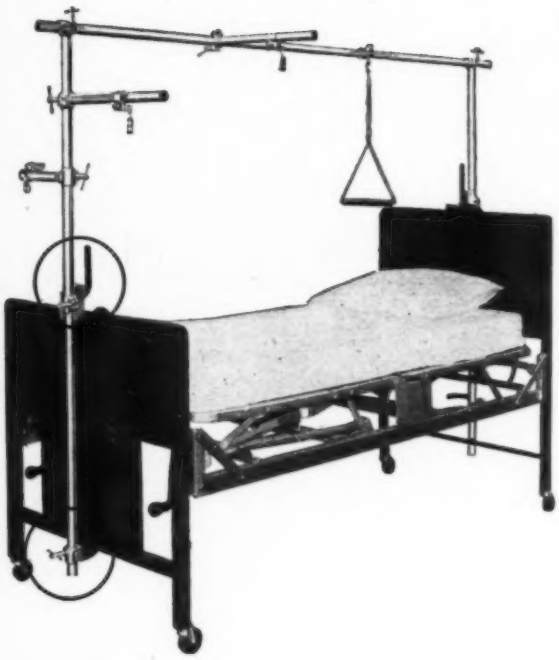

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apists under the faculty of medicine. Indeed, it would appear that the potential demand for such personnel in the Atlantic area would warrant the undertaking. Here again there is indication for study and research.

Occupational Therapists

Much of what has been stated about physiotherapists applies equally to occupational therapists. They are also members of the medical rehabilitation team. There are now only three occupational therapists in the hospitals of this province—two are in the Rehabilitation Centre in Halifax and one is in the Victoria General Hospital. As in the case of the physiotherapists, it is not possible to forecast the number of occupational therapists that will be needed under a hospitalization plan. However, there is no question that substantial numbers will be required for regional hospitals and the more specialized institutions like the Victoria General Hospital and the Children's Hospital in Halifax.

The training of occupational therapists is conducted in the same universities that train physiotherapists. At the University of Toronto the student becomes qualified in both fields; *i.e.*, physiotherapy and occupational therapy —a very useful combination particularly in hospitals of about 100 beds. For some reason that is not too clear, it has been found very difficult to recruit students for occupational therapy. To date, under national health grant bursaries the Department of Public Health of Nova Scotia has trained only two students in occupational therapy, one of whom is employed in the Tuberculosis Sanatorium. Should Dalhousie start a school for physiotherapy, it is possible that this might also include the training of occupational therapists.

Hospital Pharmacists

In the modern active treatment hospital the pharmacy is the most extensively used therapeutic facility in the institution. Moreover, the laws of most states and provinces provide that only licensed pharmacists may compound prescriptions. Therefore the pharmacist in the hospital has a rôle of prime importance. At the present time only seven hospitals in Nova Scotia have been able to secure the services of a full-time pharmacist. These are the Children's Hospital, Halifax Infirmary, St. Joseph's, St. Elizabeth's, St. Rita's, St. Martha's and the Victoria General.

The only source of training of pharmacists in the Atlantic provinces is the College of Pharmacy at Dalhousie University. The expansion of facilities and services necessarily implied by the implementation of a hospitalization plan will substantially increase the demand for both part-time and full-time pharmaceutical services in hospitals. Joint study of the problem by the Nova Scotia Section of the Maritime Hospital Association and the College of Pharmacy would seem to be indicated. It has been suggested that every hospital of 75 beds or over should employ either the part-time or full-time services of a registered pharmacist.

Medical Social Workers

The importance of medical social services in the hospital setting has long been appreciated. At present only two provincial hospitals have the services of full-time medical social workers. These are the Children's and the Victoria General. The latter hospital has five. The present shortage of beds, which will be made more apparent by a hospitalization plan, makes almost imperative the need for an effective liaison among the patient, the family, the doctor, the hospital and the community. This liaison can best be carried out by a trained medical social worker.

Here again there is need for proper study and research. This could well be a joint project of the Nova Scotia section, Maritime Hospital Association and the Maritime School of Social Work, which trains such personnel.

Laboratory Personnel

From Table 2A it is seen that, as of January 1958, 82 registered laboratory technicians were employed in the province, and that it is estimated that in 1959 a total of 121 will be required, and in 1965, 162 will be necessary. This means that in 1959 there will be a shortage of 39 registered technicians, and that by 1965 the total number of technicians will have to be doubled.

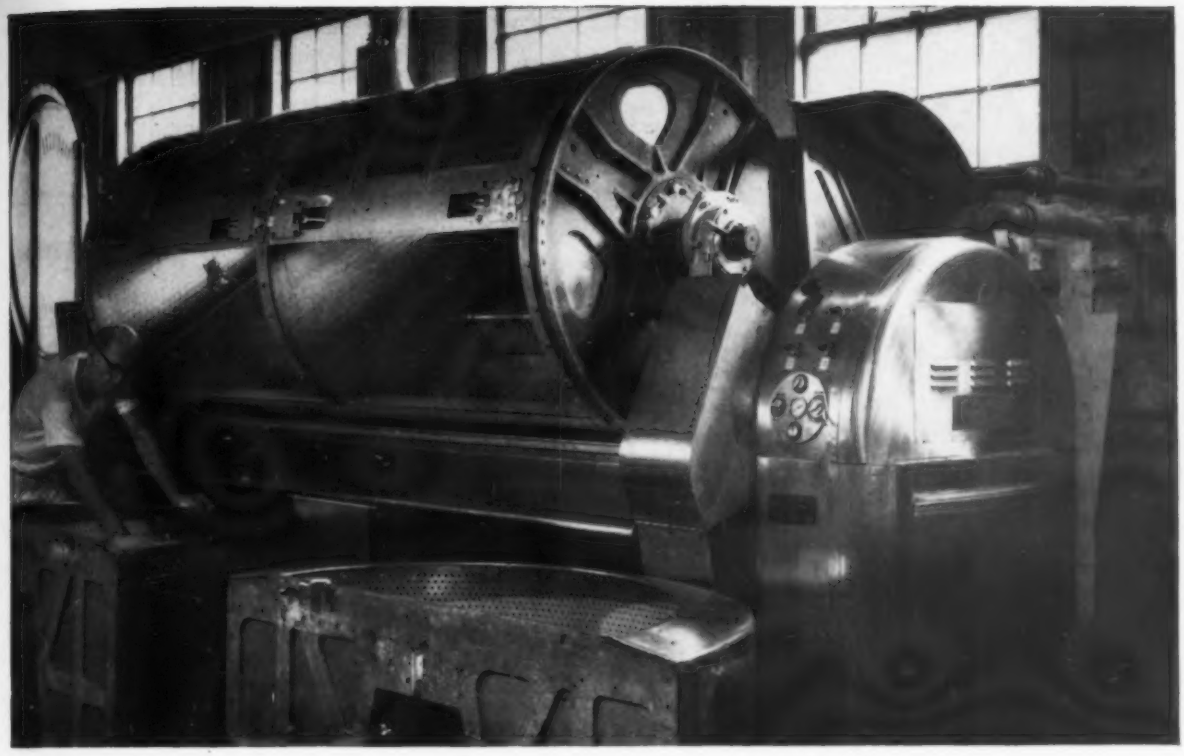
The training of registered laboratory technicians is being carried out in three main centres. In 1957 the Central Laboratories had 27 trainees, St. Martha's six, and the Halifax Infirmary four, making a total of 37. In 1959, in order to provide a sufficient number of personnel to staff laboratories, and allowing for resignations (laboratory technicians resign at the rate of approximately 15 per cent per annum) it is estimated that 75 students should be in training. In 1965 it is estimated that a student enrolment of 50 would be adequate. In other words, once the deficiency has been met, a lower level of training would be required to maintain the same level of personnel. A large enrolment of students in 1959 would have as its purpose the rapid overcoming of the deficit of registered technicians in the early years of the hospitalization program. The main obstacles are lack of instructors, inadequacy of space, and difficulties of recruitment. It is practically certain that the training program will have to be stepped up gradually and spread over a longer period of time. Unfortunately, increased training, difficult as it would be, represents the only practical way to offset staff shortages. It is almost impossible to bring in trained individuals from outside the province.

It is important that more combined technicians be trained in order that the demands for such personnel by the smaller hospital be met. The training of these technicians is carried on in Newfoundland under the Newfoundland combined technicians course, and national health grant bursaries have been available for the students. In 1957 there was only one trainee. It is estimated that there should be 12 trainees in 1959 and that there should be, in 1965, four; again demonstrating that once the demand is met a lower level of training may be feasible. The importance of the registered laboratory technician in the hospitalization plan needs to be recognized. Training bursaries covering formal training in short courses should be continued, and personnel policies should be such that laboratory technology should come to be regarded as a desirable career for men as well as women.

Radiological Technicians

In Table 2C it will be noted that there were 49 registered x-ray technicians in the province as of January 1958. It is estimated that in 1959 the province will require 74, and that by 1965 a total of 102 will be required. Experience shows that x-ray technicians cease practice at the rate

(concluded on page 96)



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◄ Provincial Notes ►

British Columbia

An extension to Grace Hospital, Vancouver, to cost $819,519, has been designed by architects Mercer and Mercer, Vancouver. Plans call for a five-storey building which will contain administrative offices to replace those in the existing structure. There will also be new bassinets, operating and labour rooms and facilities for doctors, medical staff and students.

Planned to replace the North Vancouver, is a 283-bed two-corridor type of hospital, designed by architects Underwood, MacKinley and Cameron, Vancouver. The six-storey building will permit the addition of three more floors when they are required, thus allowing an expansion to 600 beds. Cost of the structure is estimated at $4,413,000, and it is believed the entire project will cost about $6,000,000.

Victoria's St. Joseph's Hospital is planning a new $1,250,000 wing. Expansion plans include $750,000 for 87 beds and greater delivery room facilities in the new wing, and $500,000 for replacement of existing patient areas with 56 beds by service areas.

Alberta

Plans to establish a muscular dystrophy unit at the University of Alberta Hospital, Edmonton, have been announced. The unit will be the first of its type in Canada to probe into this disease, and will concentrate on research rather than treatment. All muscular dystrophy sufferers, as well as their relatives, will be invited to participate in the study.

Saskatchewan

Architect Frank W. Moore, Prince Albert, will prepare preliminary plans for an addition and renovations to Big River Union Hospital, Big River.

The University Hospital in Saskatoon recently completed a $100,000 expansion of its x-ray facilities with the acquisition of a $25,000 machine which provides automatic processing of x-ray plates. The machine processes the x-ray film fed into one end, dries it, and delivers the finished plate from the other end in just six minutes.

Manitoba

Thompson is to have a new permanent 30-bed hospital which will be designed by architects Waisman, Ross and Associates, Winnipeg.

Work has begun on the new addition to Wawanesa and District Memorial Hospital, Wawanesa. This addition will provide a new three-bed ward, a nursery, case room and extra service rooms.

Ratepayers in the area of Winkler Hospital, Winkler, voted against a money by-law which was to provide a new nurses' home.

Ontario

Renovations to the old section of St. Joseph's Hospital, North Bay, have been completed, ending a program of new construction and modernization begun several years ago. Patients' rooms in the old section were completely renovated to bring them up to the standard of those in the new six-storey extension opened last year. The hospital now provides 217 beds. In addition to this, the nurses' training school facilities were enlarged, and the chapel was redecorated.

The Civic Hospital, also in North Bay, is planning a 100-bed extension, now that government approval of the scheme has been granted.

A new wing, to replace the obsolete Miller wing, is being planned for Parry Sound General Hospital, Parry Sound. The building, designed by architects Dunlop, Wardell, Matsui and Aitken, Toronto, will have four floors and will cost $706,600. The main floor is to house hospital services; the second and third will each contain 25 beds; and the fourth floor will provide 32 beds for chronically ill patients.

The cost of additions during the next ten years to Grace Hospital, Windsor, has been estimated at approximately $2,125,000. Plans call for a six-storey building with basement, which would provide accommodation for 214 beds and 55 bassinets.

New equipment is being installed in the x-ray department of Port Hope Hospital, Port Hope. The department is being remodelled with a view to its transfer to a new wing when more space is available. A mobile x-ray unit, costing $2,032, has also been acquired.

Construction has begun on a $700,000, five-wing addition to the Ontario Hospital, Whitby. There is to be a new male treatment wing, male ward wing, female treatment wing, female ward wing, as well as an administration and reception wing.

A 122-bed addition is planned for St. Joseph's Hospital, Peterborough, at an estimated cost of $1,930,000. A new wing will be built, but the number of new beds includes some replacements in the 1889 wing. Peterborough's Civic Hospital is also planning a new wing to give an additional 120 beds. Cost will be approximately $1,500,000.

Donations to Branson Hospital, North York, have been received from the Avenue Road Lions Club ($10,000) and the Dominion Stores ($8,000). The money will be used to aid the hospital's expansion program, which will include work on the main structure as well as the construction of a new 51-bed nurses' residence.

Work has begun on the Walter T. Connell wing of the Kingston General Hospital, Kingston. Designed by architects Drever and Smith, Kingston, the wing is to cost an estimated $2,151,200.

The new $1,400,000 wing of the Doctors' Hospital in Toronto was opened recently. Designed by James Crang and George Boake of Toronto, the 11-storey structure adds 140 beds to the hospital privately owned by Drs. Samuel, Alexander, Saul and Benjamin Raxlen. The hospital is completely air conditioned and five floors have motorized beds.

An impressive ceremony marked the opening of the recently completed 60-bed wing of the St. Vincent de Paul Hospital in Brockville. The hospital's building fund was aided by many generous contributions. Among the most appreciated

of the gifts was $5.00 in nickels, dimes, quarters and pennies from the Eighth Brockville Cub Pack, and a set of dishes for the new children's ward from the Fifth Brockville Brownie Pack.

Quebec

Construction of a 28-bed floor at a cost of $175,000 is planned by Hôpital Jean Talon, Montreal. The addition will be built on top of the west wing and will bring the hospital's capacity to 183 beds.

A new hospital will soon be constructed at Amqui to be operated by the Sisters of Hope. It will provide 75 beds and will cost between $800,000 and $1,000,000. Future expansion needs will be kept in mind when the hospital is built.

Work is under way on two additions to Hôpital St-Sacrement, Quebec City. One is to cost $300,000, the other $1,500,000. The architect is Pierre Rinfret, Sillery, Quebec.

The St. George's Lodge No. 10 A.F. and A.M. of Montreal presented the Jewish General Hospital, Montreal, with a photo-electric instrument to be used in the haematology department for blood count analysis.

Plans are being prepared for an extension to the Hôtel-Dieu de Montréal by architects Gascon, Parant and Auger, Montreal. The extension will include a wing to house a dispensary and an emergency admitting room.

An extension, to cost approximately $70,000, is being planned for Hôpital Notre-Dame-de-la-Merci, Montreal. The architect is Roland Dumais, Montreal.

It is expected that construction on a regional hospital for Lachute, which is to be operated by the Sisters of Providence, will soon begin. It will cost an estimated $900,000, and will contain approximately 60 beds. Plans call for a single storey modern building with two wings—one maternity, and one medical-surgical.

Fleury General Hospital, serving Montreal's north-end residents, is to receive a new wing which will raise the hospital's bed capacity to 225. The wing has been designed by architects Roux and Morin, Montreal. Construction of a nurses' residence is also planned.

New Brunswick

The new St. Joseph's Hospital, costing approximately $3,500,000,

(concluded on page 102)

Physiotherapists

(concluded from page 37)

physiotherapy services with no strain on the hospital budget. These figures should be investigated further because our question did not demand sufficient detail as to how these figures were to be calculated. It did not specify whether the proportional cost of the space occupied by the department, maintenance, cleaning, lighting, apparatus repairs and replacements, as well as salaries, were all to be taken into account. The compiler intends to follow up this question at a later date in order to obtain fuller information.

Distribution of Treatments and Departments

The full report from the Dominion Bureau of Statistics, entitled "Hospitals Reporting Physiotherapy Departments"* is most revealing. It gives facts which indicate that 51.2 per cent of the hospitals have unqualified personnel administering physiotherapy techniques, 30.7 per cent have departments directed by qualified therapists and 18.1 per cent claim that infra-red treatments are given.

The above report divided physiotherapy services into five categories: advanced hydrotherapy, induc-to-thermo-therapy, infra-red therapy, massage and manipulations, and ultra-violet therapy. The infra-red column has been discarded because every hospital uses infra-red in one form or another and its use is not confined to physiotherapists. The hospitals claiming to employ three or more techniques other than infra-red, but having no department, have been counted according to size of hospital. Sixty-three small, ten medium, and two large hospitals, spread over all but one of the provinces and irrespective of the existence or absence of legislation, give physiotherapy treatments without the direction of a qualified therapist.

Table 12 shows the distribution, according to size of those hospitals not claiming physiotherapy departments.

Further investigation of facts underlying these figures would be valuable to ascertain if patients are receiving the standard of treatment to which they are entitled.

The preceding five sections provide the highlights of data obtained in four of the objectives of this study. The second section of the report, to appear in the September issue, will deal with the fifth objective and will contain the summary and conclusion.

Table 11

Range and Average Cost of one Physiotherapy Treatment by Size of Hospital

Hospital beds	Range of cost per treatment	Average cost per treatment	No. of hospitals reporting
1-199	$2.58 — .66	$2.03	14
200-499	$3.25 — .63	$1.70	19
500 and over	$2.68 — .68	$1.63	20

Table 12

Hospitals Claiming to Give Patients 3 or More Physiotherapy Techniques Without a Department of Physiotherapy and No Qualified Therapist, by Size 1957

No. of Beds	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
1-199	0		4	4	12	9	1	14	8	11
200-499		2	1		4	3				
500 and more					2					

**D.B.S. Unpublished Report 1957 "Hospitals Reporting Physiotherapy and Occupational Therapy."*

Diet Teaching Centre

In January, 1957, a dietitian-nutritionist was appointed to organize and direct a diet teaching centre in the Montreal General Hospital. This centre was to co-ordinate all nutrition and diet teaching throughout the hospital, and to provide nutrition and diet education for patients in the medical out-patient department.

The first step is being achieved through consultations with staff dietitians, social workers, and medical interns; through special instruction with post-graduate interns; and through lectures to medical students.

The second part of the program concentrates upon teaching ambulatory patients both to understand their dietary prescriptions in relation to their medical condition and to look after all the details of their own meals at home. The centre makes it possible for such education to be continued with formerly hospitalized patients, now receiving treatment on an "out-door" basis, and to be begun with those ambulatory patients who have never been hospitalized.

Patients, who are sent to the diet teaching centre by doctors and interns, have their dietary prescriptions interpreted for them in a quiet, pleasant atmosphere. The dietitian - nutritionist interviews each patient in order to gain his nutritional history. With this knowledge serving as background, she plans the patient's diet and encourages him to assume the responsibility for following it. To make her lessons more effective, the nutritionist makes extensive use of teaching aids—wax food models, diagrams, felt board exhibits, posters, leaflets and pamphlets. Material the patient can take home, such as that produced by the federal nutrition division, is especially helpful.

The teaching is now mainly individual, but perhaps on some future date group education will be carried on. At any rate, the diet teaching centre has shown itself to be an extremely practical service.—*By Doris Norman, dietitian-nutritionist, Montreal General Hospital. "Canadian Nutrition Notes".*

Good health is born of the earth, the sun, and the cooking pot.—*French Proverb.*

New Rehabilitation Centre in New Brunswick

At Fredericton, N.B., The Forest Hill Rehabilitation Centre Inc., is a new centre which was officially opened on May 2 of this year. It is two miles out of the city, close to the new Trans-Canada Highway, and has a background of beautiful New Brunswick forest.

The centre is designed to provide in-patient and out-patient physiotherapy and occupational therapy, for rehabilitation of the patients in the province. Its plans include 20 in-patient beds and service for up to three times as many out-patients. It will not serve as a convalescent hospital or a nursing home, but a hospital where patients will receive therapy which will assist them to return to work at as early a date as possible, or help them to be capable of adapting to a new occupation.

The physiotherapy department is compact, with four treatment cubicles well stocked with standard electrotherapy equipment and plinths. Hydrotherapy is carried out with whirlpools and a large Hubbard tank housed in the same room as the cubicles. The large, spacious gymnasium is well adapted for a rehabilitation program.

The occupational therapy department is not intended to teach patients new trades and skills, but provides an opportunity for patients to condition themselves to working habits so that they can develop the highest possible degree of physical skill for their return to their regular employment or to a new occupation, when necessary.

The operation of the centre is on a non-profit basis, and the cost is to be paid on a per diem basis by organizations and agencies using the service, such as the Provincial Government Rehabilitation Division, Polio Foundation, Workmen's Compensation Board, and the Department of Veteran's Affairs.—*J. D. Ross, F. F. Ph from Journal of Canadian Physiotherapy Association.*

Home Helps Abroad

Among the most valued community services for families are the programs to provide home helps, or "visiting homemakers". In almost every country in Europe they are considered a very essential part of service to families. Perhaps the most tangible evidence of the value placed on this assistance is the fact that these services are usually organized by local health or welfare agencies, or receive considerable subsidy from the local or state governments.

In Britain, the administration of the home help service seems to be under the local health authority; at least it has the responsibility for selecting those families most in need of service. These services are not provided free of charge but charges can be adjusted to ability to pay.

In several other countries home help services are very well established. One reason for this is the fact that specific educational programs have been developed for the training of these workers. This gives the positions increased status and stability, and ensures the high quality of the service. Sweden and the Netherlands, in particular, have extensive training and service programs.

The program in the Netherlands is unique because it has been developed specifically to fill a need for help in home confinements in a country where almost 80 per cent of babies are born at home.—*Canada's Health and Welfare.*

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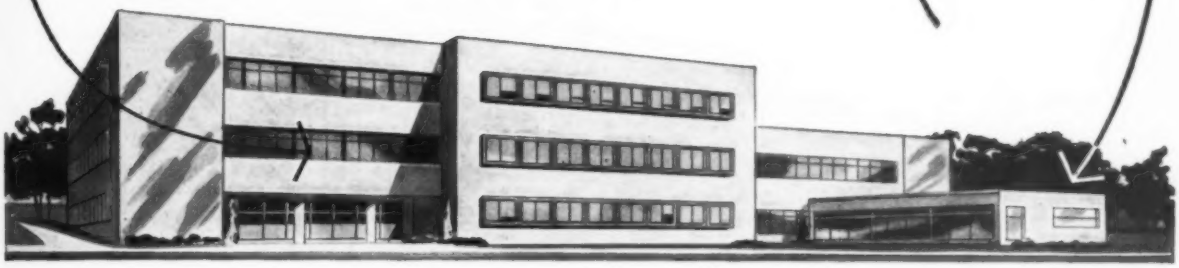

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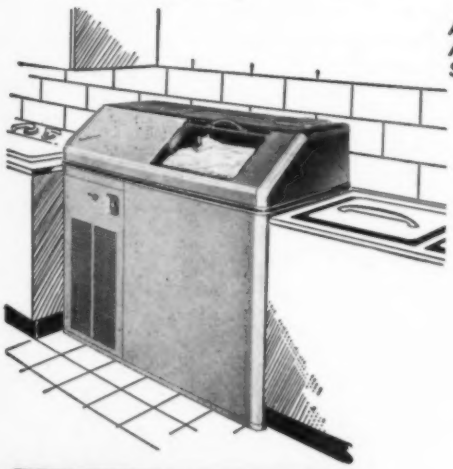

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Twenty Years Ago

From the Canadian Hospital, August 1938

In the Vancouver General Hospital four gallant youngsters, long-term patients, are carrying on a publishing enterprise under conditions which would stump the most hardened newspapermen. The "Ward-Revue" may appear rather spasmodically, but it's pretty difficult to get a paper out on time when editor, manager, and sub-editor spend all their time in hospital cots.

A recent edition, with a circulation of 50 copies, mimeographed on a nearby school machine, brought in $1.12. Most of the money is put aside for the purchase of their own mimeographing machine, so that in future all the work can be done on the ward. Aim—circulation of 100 copies.

Visitors to London, England, may have thought they were witnessing an up-to-date gas mask parade or perhaps a British version of the Ku Klux Klan when they saw a recent parade of 20,000 nurses, masked and in uniform and bearing sandwich boards and banners protesting the long hours required of nurses. The London County Council capitulated and reduced their working hours from 54 to 48 hours a week. By this change, 1,000 additional nurses will be employed at an additional cost to the L.C.C. institutions of $615,000.

At the recent session of parliament in Ottawa, the Bill to legalize lotteries for the benefit of hospitals and universities was talked out. Speaking against the measure, Honourable R. B. Bennett said:

"I cannot give a silent vote on this bill. The Criminal Code, rightly or wrongly, has declared against gambling and lotteries; that represents a crystallized public opinion which has prevailed for many years. There are exceptions and this seeks to extend the exceptions.

Every now and then some country appointed a commission to investigate sweepstakes and invariably the finding was they were undesirable. It might appear they would help certain institutions, but experience showed that in the long run, funds from such sources dried up and then it was found people were unwilling to make voluntary contributions to charity.

Is it desirable to encourage the idea that fortunes come by chance, that funds for hospitals and universities come by chance?"

In the individual, sweepstakes were conducive to begging and sometimes to stealing. People became willing to do anything in order to get the money to buy tickets to risk all on a vain delusion "and never was a more vain delusion than the thought that in the end you can get rich by chance."

Dietitians' Act

The Professional Dietitians' Act came into force in Saskatchewan on May 1 of this year. Under this Act, all dietitians working in the province must be registered with the Saskatchewan Dietetic Association. Hospitals there are asked to change the designation of anyone who has not qualified for membership in the provincial dietetic association from "dietitian" to some other title. — *Sask. Hosp. News Bulletin.*

THE CANADIAN HOSPITAL

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Medico-Legal Problems

(continued from page 55)

1 W.W.R. 989, the British Columbia Supreme Court found against a surgeon who tied the patient's fallopian tubes while performing a caesarian section because he discovered fibroids in the uterus and decided that she should not have any more pregnancies. It was held that the question for decision was not whether the time was a convenient one to perform the further operation without the patient's consent, but "whether such an emergency existed as to make it necessary to do so". As there was no evidence that the fibroid tumors were then dangerous to her life or health, but only that they might constitute a hazard in the event of another pregnancy, the plaintiff was held to be entitled to damages.

Part III of this article will appear in the September issue.

Hospital Built in an Hour

A 100-bed hospital, complete with operating theatre, was recently flown from the United Kingdom to a USAAF base in France by three air freighters. Assembly took less than an hour.—*Financial Post.*

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DIVERSEY. SANITATION CHEMICALS

H.O.M.

(concluded from page 51)

partment, and Walter Hatch, administrator of Kitchener-Waterloo Hospital, Kitchener, spoke on engineering and maintenance. Paul D. Shannon from the Royal Victoria Hospital, Montreal, S. W. Martin of the O.H.A., and Murray Ross of the C.H.A., all discussed accounting. Medical records were explained by Dr. Margaret McGuire, Winnipeg General Hospital; Douglas Wickenden, Toronto East General and Orthopaedic Hospital, spoke on purchasing; Margaret E. Ketchen, Toronto General Hospital, on the dietary department; Dr. W. Harry Botterell, senior surgeon at the Toronto General Hospital, on rehabilitation programs, and Dr. A. T. Jousse, Lyndhurst Lodge, Toronto, on physical medicine; Gerald P. Turner, New Mount Sinai, on volunteer workers, Donald J. Duff and staff members of Brakeley and Co., on fund raising and public relations. Several lectures were also given by J. Gilbert Turner, M.D. of the Royal Victoria Hospital, Montreal.

A series on nursing, which covered nursing service, standards, budget, administrative patterns and in-service education was given by Kathleen Ruane, R.N., director of nursing at the University Hospital, Saskatoon, and by Norma Wylie, director of the in-service education program at Vancouver General Hospital.

Other outstanding lecturers included Dr. Charles U. Letourneau, director of programs in hospital administration at Northwestern University, Chicago, who spoke on hospitals and law, and hospitals of the future. The federal government contributed through Dr. K. C. Charron who covered the topic of hospital insurance plans; Dr. Gordon E. Wride, on federal grants and Fraser Harris, of the Dominion Bureau of Statistics, on statistics and research.

Tribute is due to the 15 moderators who for the evening sessions guided and promoted discussion on the students' papers. All told, approximately 44 lecturers gave generously of their time to ensure a successful course.

The United States of America is rapidly becoming the softest nations in the world . . . and there is no reason to believe that Canada is doing any better." — *Monthly Letter, Royal Bank of Canada.*

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With "Foaming Action". Now contains bleach—gets all surfaces brighter with up to 50% less effort—even in hardest water. Packed in 48, 14 oz. tins per case and 150 lb. drums.

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C.D.A. Convention

(concluded from page 61)

No one to date has the magic formula. There are many kinds of nutritionally adequate diets available. She considered the following as being essential to a good reducing diet: that it contain all the nutrients needed; that it protect from between-meal hunger and from fatigue; that it be fairly easy to obtain and not too different. Dr. Young feels that some of the answers to the prevention of obesity are a more intelligent understanding of its problems, better food habits from earliest childhood on, education for greater planned physical activity, and education for more constructive use of leisure time.

Another speaker who stressed the importance of good food habits learned early in life was Dr. Ruth Leverton, associate director, Institute of Home Economics, United States Department of Agriculture, Washington, D.C., who discussed "Feeding the Teenager". Studies show that calcium and ascorbic acid are the nutrients most likely to be in short supply in "teenager" meals. One group of girls in Oklahoma, guilty of omitting breakfast regularly, had reduced calcium and iron intakes. As well, 18 per cent of their total daily calories came from snacks, while other girls who ate breakfast had only seven per cent of their total calories as snacks.

A fine banquet and another fine speaker brought the annual convention to a close. Mavor Moore, television personality, author, producer, composer, told of "The New Challenge Facing the Arts". The horizon confronting the artist has expanded greatly, Mr. Moore explained. Many things once thought of as a dream have really happened; for example, the range between science and science fiction is much closer than formerly. Since art still represents the principle of life amidst all the confining facts science gives us, Mr. Moore warned against letting the shell (science) conquer the life.

Manitoba Budget Institutes

A two-week period during April was devoted to the presentation of institutes on the preparation of hospital budgets, in view of the Manitoba hospital insurance plan. The meetings were well attended by approximately 125 people from over 70 hospitals in Manitoba.—*A.H.M. News.*

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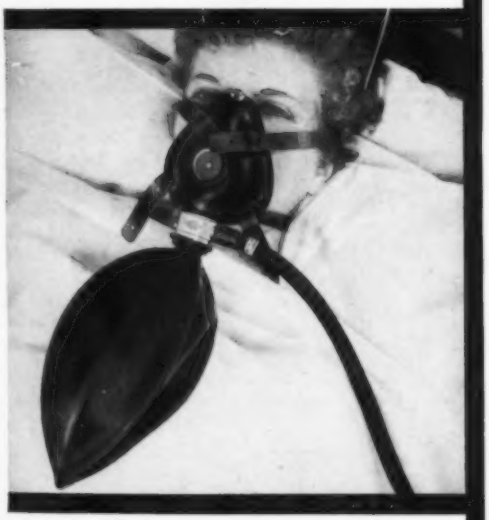

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Financial Control

(concluded from page 49)

working independently checks the activities of the other. An example of the principle is that the receipts of the accounts receivable cashier would equal such credits as posted by the accounts receivable clerk. There are other parts to effective internal control, but this example is sufficient to indicate the meaning of the term which can be extended to include internal audit.

While most big business concerns employ internal control in its broadest sense in the management of their affairs, it is the exception to find its application in hospitals. Nevertheless, it is a desirable and useful arrangement if full financial control is to be attained.

Audit

The employment of independent public accountants as auditors is a prudent arrangement for assuring administration that its financial statements exhibit a true picture of financial operation and position. The engagement of independent auditors is just another part in the accounting processes useful in bringing about financial control.

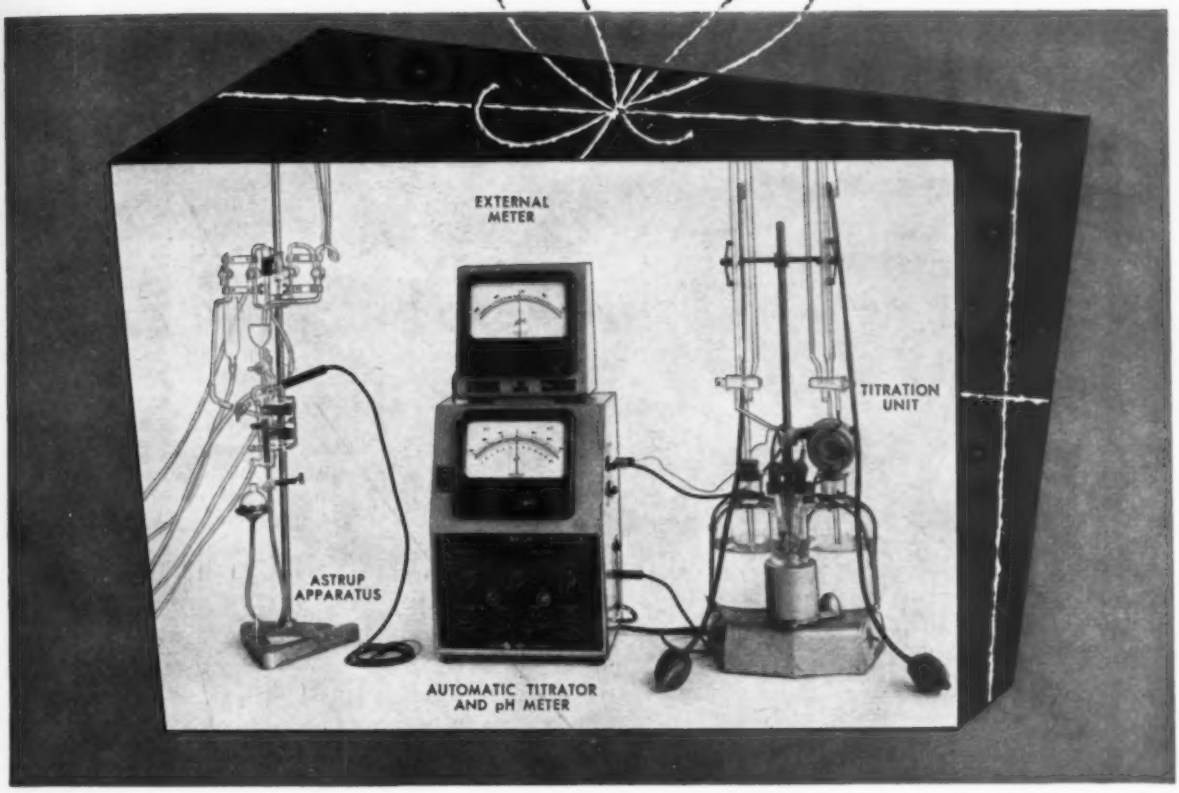
Conclusion

A characteristic of effective administration is its ceaseless seeking to accomplish objectives at the least possible cost. Naturally, such a program can only be carried out where there is control over the economic activities. Because a knowledge and use of costs is involved in the effort to attain objectives, it can be said that "without accounting there can be no financial control." This explains the emphasis given here to the accounting function in its many parts.

For some reason, the assigned subject, general principles of financial control, brings to mind the quotation, "A man's reach should exceed his grasp or what's a heaven for?" This is because it must be understood that full and complete control can never be realized, and that the effort in this direction is more like a road to travel than a goal to be attained.

Only vigilance and assiduous attention to the accounting processes will keep administration on the duty road of providing the best hospital care at the minimum cost. A home-made jingle sums up and shows the way: "to reach your chosen goal you must control the *whole*."

A package Hospital Clinical Laboratory..



...for standard pH measurements...automatic titrations... astrup blood determinations...standard clinical determinations

From the initial package, additions can be made economically from the extensive Radiometer line of electrodes and accessories, of which only a few are listed below.

Pre-tested methods for most of the routine determinations — i.e. chlorides, blood sugar, etc., are available.

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ELS 12: Multiple Titration Selector.

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The most unique package for the small laboratory ever offered. Either manual titrations or *fully automatic* titrations can be performed (at a rate of up to 40 per hour). All the standard pH determinations including those on blood by the Astrup method — pH, pCO_2 and standard bicarbonate, can be done precisely and easily.

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Eastern Workshop

(concluded from page 57)

The third day was spent discussing the relationship between hospital administration and nursing service. As chairman of the session, Robert B. Ferguson, administrator of Humber Memorial Hospital, Weston, set the tone for a discussion of a patient-centred hospital. The opening speaker, Ray Copeland, administrator of South Peel Hospital in Cooksville, posed a series of questions which suggested possible difficulties in the relationship. Ella M. Howard, director of nursing of New Mount Sinai Hospital, Toronto, spoke of how the director of nursing looks to the administrator—she expects him to set a tone for the institution, an emphasis on patient care. Nursing supervisors, Miss Howard felt, should be trained in administration and prepared for their responsible positions. Good supervisors and head nurses attract and retain staff. Miss Howard felt too that the administrator and the director of nursing should combine efforts towards giving nurses an understanding of policies and conditions under which they are employed. "Because it is easier than trying to get the intern to do it," nurses are taking on duties which are not properly theirs—this trend Miss Howard opposed.

For the Wednesday afternoon session Mr. Ferguson, Mr. Copeland and Miss Howard were joined by L. H. Parsons, administrator of the Oakville-Trafalgar Memorial Hospital, and E. W. Roeder, administrator of the Alexandra Hospital in Ingersoll. Mr. Roeder discussed the responsibilities of the director of nursing in interpreting to the nursing staff the policies established by the administration. Interesting discussions developed as to whether the director of nursing might not better be considered as assistant administrator, nursing service. Two members of the group felt that this was already true in their hospitals.

At the end of the afternoon sessions on the 18th, the 35 persons attending expressed their appreciation to the speakers, and to the planning committee which was composed of Boyd McAulay of Toronto Western Hospital, chairman; George Thornton of the Wellesley Division of the Toronto General Hospital, president of the Alumni Association; L. L. Wilson, assistant director of the Canadian Hospital Association, and J. A. Keddy, director of medical records and statistics, H.S.C.

Architectural Exhibition at the A.H.A.

At the American Hospital Association's convention, to be held August 18 to 21, an exhibition of hospital architecture will be shown. The exhibits will be submitted by registered architects, and will depict hospitals or other structures for purposes of health care, diagnosis and medical treatment of illness, rehabilitation, or health education, erected or under construction in the United States or Canada.

Whatever you have, spend less. —*Samuel Johnson.*

Personnel

(concluded from page 76)

of 22 per cent of the working force, per annum. This is a slightly higher rate than with registered laboratory technicians. With this in mind, it is obvious that 50 per cent more registered technicians should be available when the plan is initiated. This takes into consideration no additional hospital beds in 1959. The Cape Breton, Fundy and Southern regions are particularly short of such staff. Of combined technicians who can do both basic x-ray technology and basic laboratory technology—who are so useful in the smaller hospitals—there is unfortunately a complete lack.

In 1957 there were 43 student x-ray technicians training in provincial hospitals. Almost half, 19, were at the Victoria General Hospital. The above figures include those in the first and second years of the two year course. In 1959, it is estimated, the number of students should be increased to 59 in order to offset as rapidly as possible the existing deficit. The number thereafter probably could be dropped to about 40. It is felt that this level of training, allowing for resignations, should be adequate until at least 1965.

Of course, there are significant difficulties to be overcome before a greatly agumented class could be enrolled in 1959. Space, teaching staff and recruitment would all pose problems. Indeed, it is quite probable that a stepped-up training program might have to be spread over several years. Bursaries for training x-ray technicians should be continued. A regular schedule of refresher courses should be instituted so that the staff might be kept abreast of the latest techniques. Personnel policies should be of such a standard throughout the province that high school graduates, particularly young men, would be attracted to this field.

Saskatchewan Plan

It has recently been announced that as of July 1, 1958, hospitals of Saskatchewan are permitted to retain 50 per cent of the net earnings from extra charges on semi- and private accommodation. These funds are to be used for the acquisition of capital assets, for the retirement of capital debt, and for payment of interest on capital debt.—*Sask. Hosp. News Bulletin.*

(Advertisement)

Disposable Syringe Medication

A Review of Advantages and Three Outstanding Examples

AN INCREASED TREND toward the acceptance and use of disposable syringe medication is evident in hospitals throughout the country. Many "standard" hospital parenteral products are now being offered in this relatively new dosage form by pharmaceutical firms. Consideration of some of the advantages of disposable items helps to account for this increasing demand.

Assured Sterility

Since some manufacturers (*e.g.*, Organon) supply a completely sterile disposable needle and syringe with the cartridge of medication, the danger of inducing infectious hepatitis or pyrogenic responses in patients is greatly reduced. In addition, the disposable units may also reduce the incidence of serum sickness and anaphylactoid reactions in hospital personnel. Protection is afforded the person preparing the injection, since no withdrawal of a needle from a vial is necessary. Thus there is little risk of puncturing or scarifying his skin.

Expedites Medication and Charges

The time consumed by nurses and pharmacists in preparing injections is greatly reduced through use of disposable units, since these are always ready for immediate use. This allows nurses to spend more time in actual patient care. In addition, since the disposable unit is completely used up after each injection, the patient need not be charged for a full multiple-dose vial nor need the hospital pharmacy assume the loss for a partially used vial.

No Waste

Precision dosages are assured in the disposable units. This decreases waste of medicament, facilitates inventory control, and increases the efficiency of the hospital pharmacy. In addition, central supply operating costs are reduced through fewer syringe breakages, and reduced need for washing, assembling, sterilizing and storing hypodermic equipment.

Better Patient Psychology

Patient comfort and well-being are increased when the patient becomes aware that the needles are used only once and discarded. In addition, each needle is new, burr-free, and sharp, minimizing the pain on injection.

Economy

Some manufacturers (*e.g.*, Organon) price their disposable units so that the hospital pays only the cost of the medication itself plus the manufacturer's cost for the disposable needle and syringe. This helps make medication administered in disposable units economical, and, when the other advantages of disposable units are considered, a real advance over the use of standard hypodermic equipment with multiple-dose vials.

In line with the trend toward increased hospital usage of disposable syringe medication, Organon Inc. of Orange, New Jersey, a pharmaceutical firm with more than two decades' experience in the manufacture and marketing of quality parenteral products, recently introduced three of its hospital products in disposable unit form. These products are Cortrophin®-Zinc, Liquaemin® Sodium, and Adrestat® (F). Each of these products is available in a package containing a 1-cc cartridge of medication and a sterile B-D®* Disposable Syringe. The packaging of this Organon disposable unit is unique in that the needle and syringe are packaged in a sterile plastic bag, assuring sterility to the moment of use.

Cortrophin-Zinc is Organon's exclusive aqueous suspension of long-acting corticotropin (ACTH) with zinc hydroxide. It provides therapeutic ACTH activity for far longer periods than can be obtained with ACTH in any other vehicle. In disposable units, Cortrophin-Zinc 1-cc cartridges are available in two strengths: 40 U.S.P. units of ACTH per cc, which provides ACTH activity for 72 or more hours, and 20 U.S.P. units of ACTH per cc, which provides ACTH activity for 36 or more hours. With its wide range of indications (over 100) Cortrophin-Zinc in disposable unit form is a valuable hospital item.

Liquaemin Sodium (Heparin Sodium) is America's first and finest heparin. Its usefulness in the prophylaxis and treatment of thromboembolic and atherosclerotic disease is well established. In disposable units, Liquaemin Sodium 1-cc cartridges contain 20,000 U.S.P. units of heparin sodium (approx. 200 mg.) in aqueous solution. This strength and form of Liquaemin provides prolonged anticoagulant activity equal to that of the same concentration of heparin in gelatin, and without the inconveniences of a gelatin menstruum.

Adrestat (F) is Organon's systemic hemostat (Carbazochrome Salicylate) indicated in the prevention and control of bleeding and oozing. In disposable units, Adrestat (F) 1-cc ampuls contain 5 mg. of adrenochrome semicarbazone (as 130 mg. carbazochrome salicylate**). This form of Adrestat (F) is particularly useful in emergency clinics and for pre- and post-operative use.

Further information on these three products as well as extra copies of this article for use in presenting the advantages of disposable syringe medication to Formulary or Therapeutics Committees may be obtained by writing to Hospital Sales Department, Organon Inc., Orange, N. J.

*T.M. Reg. Becton, Dickinson & Co. **U.S. Pat. Nos. 2,581,850; 2,506,294

(Continued on next page)

Highlights

(continued from page 40)

program until January 1, 1959. The proposed amendment will make it possible for the federal government to commence making contributions from July 1, 1958.

Exclusions

The federal Act, in its definition of cost, excludes the cost of any amount expended on the capital cost of land, buildings or physical plant; for the payment of any capital debt; for the payment of any debt incurred or for interest on that debt prior to the signing of an agreement; and any provision for depreciation on the value of land, buildings or physical plant. However, capital assistance is provided through the existing hospital construction grants. The Minister of National Health and Welfare recently announced increases in the amount of funds available for hospital construction under this grant scheme, with a broadening of the terms of reference to include not only new construction, but also major renovations and interns' quarters.

Although the federal Act specifically excludes mental institutions and tuberculosis sanatoria as participating hospitals, the Act does not exclude the treatment of insured persons suffering from mental illness and tuberculosis when they need treatment in hospitals other than those specifically excluded. The exclusion of nursing homes and custodial institutions has been prompted by the consideration that they do not meet the provisions of the Act with regard to in-patient services and, particularly, are not amenable to those basic medical controls which are inherent in the Act. For the most part, such institutions are welfare homes rather than hospitals.

Provincial Methods of Financing

The provinces are free to devise their own methods of financing that portion of the cost of insured services which are not met by the federal contributions. Four methods of provincial financing are being used by the provinces at present operating hospital insurance programs. These are premium, sales tax, general revenue, and property tax. They are being used either alone or in combination and it would appear that the other provinces are considering similar methods of financing.

Hospital insurance and diag-

nostic services form an important part of the over-all arrangements for health care. They must dovetail with other health services so that the best possible use will be made of our health resources. The quality of care and effective utilization of beds have always been matters of considerable concern to those responsible for the operation of hospitals, and these factors become more important in a publicly supported program.

For the last decade, the national health grants have provided assistance to the provinces in the strengthening and expanding of health services. In the absence of hospital insurance, considerable grant funds have been made available for services in hospitals which will now come within the purview of the hospital insurance program. Where assistance is provided by hospital insurance, grant funds will not be used. A careful and detailed study is being carried out in order to avoid duplication and gaps between the two programs. In addition, with the inception of the hospital insurance program, new needs may be anticipated. Some of these have been discussed in connection with technical assistance which will be provided under health grants. With the dovetailing of the health grants with hospital insurance, it is anticipated that a wide program of assistance for health care in Canada will now be available to the provinces.

Control of Standards

(concluded from page 47)

representatives should include board, administration and medical staff. In addition there might well be special members on the regional standards committee, such as the divisional medical health officer.

The regional standards committee, which should meet about quarterly, would attempt to raise the standard of patient care in the region by means of studies, practical research and education. Individual members or groups of members might undertake, with statistical and other assistance from the provincial level, special studies on hospital matters. Panel discussions and expert guest speakers could ensure that the hospitals in the region were kept abreast of the latest advances in hospital care. It is not unlikely that Dalhousie University, with its interest in medicine, nursing, et cetera, would be pleased to provide special speakers and otherwise interest itself in the work of the regional committee. The Planning Commission, not without reason, has felt that a regional standards committee, by means of studies and education, could have a profound effect in raising the standard of patient care in our hospitals.

At the provincial level, it is felt that the proposed hospital insurance commission should act as a *provincial standards committee*. To assist the provincial standards committee, it is considered that there should be a professional technical advisory committee. This latter committee would be composed of acknowledged and accepted experts in a number of fields having to do with the operation of hospitals. By seeking advice from such authorities, the commission should be sure of making sound judgments.

In addition, there would be on the staff of the commission a number of trained counsellors in such specialties as nursing, laboratory technology, x-ray technology, medical social work, pharmacy and dietetics. The function of these counsellors would be to advise and assist the hospitals. There is little doubt that they would play a major rôle in raising the standard of services in our institutions.

In this presentation, I have attempted to establish the premises upon which our thinking is based. If these premises are accepted (and we believe they are acceptable because they are supported by tradition and authority) then the thinking based on these premises should be also generally acceptable. Of course, we appreciate that when we "flash out" the skeleton of our plan, there will be certain "bumps and lumps" that will be aesthetically repugnant to some at least. However, we also believe that good will, consultation and genuine "give and take" will serve to smooth out these "bumps and lumps" so that we may wind up with a "Venus de Milo" of a plan which we all, sitting back, in our old age, can contemplate as a real work of art!

Bibliography

1. *Hospital Organization and Management*, Third Edition, MacEachern, p. 85; p. 93.
2. American Hospital Association, *Code of Ethics*.
3. v Report of the Hospital Services Planning Commission, ch VIII, pt. iii.

Chicago Institute

The 26th Chicago Institute for hospital administrators will be held this year from September 2 to 12 at the University of Chicago. Topics under discussion will include medical staff, personnel relations, legal aspects, financial controls, community relations, executive functions and techniques, departmental administration, and governing bodies.

Conducted by the American College of Hospital Administrators, the institute will feature lectures in the mornings, followed by group discussions and field trips in the afternoons. These field trips will take those attending the institute to hospitals of their own choice in the Chicago area. There will be some discussion meetings and organized social activities in the evenings, but free evenings will be available for sight-seeing.

The institute is open to administrators and assistant administrators of listed hospitals.

A guest towel is what often persuades people their hands don't need washing after all. — *Mark Twain.*

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Operating Room Supervisor

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400 bed hospital

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Qualifications: post - graduate certification in operating room technique and management with experience.

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Dietitian Wanted

For 75 bed hospital, to take charge of dietary department and teach dietetics in the School of Nursing (approx. 35 students). Excellent working conditions, personnel policy and salary. Apply to A. J. Schmiedl, Administrator, Dauphin General Hospital, Dauphin, Man.

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The hospital has approved schools for nurses, laboratory technologists, x-ray technicians, and is approved for intern training.

Qualifications for applicants include registration in Ontario, at least a bachelor's degree in administration, and successful experience in the field of nursing education as well as in nursing administration.

For more details and literature concerning the position and Sarnia, write to:

Personnel Director

Sarnia General Hospital

SARNIA, ONTARIO

Director of Nursing

New modern general hospital in Northern Ontario requires Director of Nursing, duties to commence November 1, 1958. 42 adult beds, 11 bassinettes. Must have experience as Director or Assistant Director of Nursing.

Salary Range $349.00 to $469.00 monthly. Welfare benefits available. Give details of training, experience, post graduate studies, and references in letter to—Administrator, Anson General Hospital, Iroquois Falls, Ontario.

Dietitian Wanted

Assistant to chief dietitian required for new 250 bed General Hospital. Modern Dietary Department, Cafeteria and trayveyor service. Excellent working conditions and personnel policies. Full details of position available to applicants. State qualifications and experience. Apply to Chief Dietitian, Sudbury Memorial Hospital, Sudbury, Ontario.

Dietitian Wanted

Chicago hospital has opening for qualified dietitian to instruct student nurses in diet kitchen, take charge of special diet kitchen and general therapeutic diets. Salary $351-367 per month to start plus two meals per day. Forty hour week. Apply to Box 810G, The Canadian Hospital, 57 Bloor Street West, Toronto 5.

Position Wanted

Graduate of the University of Toronto Course in Institutional Management with eleven years experience in Resort Hotel and Club Management wishes to enter the hospital field and take the C.H.A. course. Desires position in Business or Administration capacity. Prefer small city or town. Please write Box No. 723H, The Canadian Hospital, 57 Bloor Street West, Toronto 5.

Assistant Medical Record Librarian Required

for 427 bed hospital, experienced. Apply to Assistant Administrator, Hotel Dieu of St. Joseph, Windsor, Ontario.

Staff Pharmacist Required

For 250 bed hospital. Reply by mail to: Chief Pharmacist, Sudbury Memorial Hospital, Regent Street South, Sudbury, Ontario.

Classified Advertising

continued

Home Care Programs in U.S.A.

Twenty-three prominent physicians, nurses, social workers, hospital administrators and public health officials meeting in Roanoke, Virginia, last June, considered organized home care programs in the United States. The group urged a more widespread development and support of community programs (there are now about 50 in the United States) by federal, state, and local health and welfare agencies, health and health-related professions, and health insurance agencies.

Their major recommendations were:

- The Public Health Service should support demonstration programs to initiate and stimulate organized home care programs in various communities.
- Prepayment plans should meet the challenge of financing such programs. Funds should be made available for studies of this plan.
- Public welfare agencies should pay full reimbursable costs for services to their clients.
- Health and health-related professions should give special attention to the recruitment and training of personnel needed in organized home care programs.

The group defined the program as follows: "Organized home care provides co-ordinated medical and related services to selected patients at home through a formally structured group comprising at least a family physician, a public health nurse, and a social caseworker, assisted by clerical service. To insure satisfactory functioning of such a service, patients must be formally referred and there must be an initial evaluation, monthly review of records, and a final discharge conference. There must be ready access to in-patient facilities."

It was felt that the patient would benefit through the security of his own home and family, yet at the same time he would know that his treatment was in the hands of a group of health professionals, working with his own physician, and that a hospital bed was waiting, should he need it. Such programs provide service to patients of all economic levels, and assist the physician in his job.—*U.S. Public Health Service.*

Any man who says that women aren't good listeners should be careful how he talks. — *English Digest.*

Provincial Notes

(concluded from page 79)

was opened recently in Saint John with an impressive ceremony. The completely modern structure, designed by architects Govan, Ferguson, Lindsay, Kaminker, Langley and Keenleyside of Toronto, has beds for 181 adults and 25 children. It also provides 50 bassinets. In full operation this month, the hospital offers many new facilities, such as a medical library, an elaborate intercommunication system, and five operating rooms equipped with the latest lighting units.

The Provincial Hospital, Campbellton, is planning a new wing which will provide 225 additional beds as well as other facilities. This $1,500,000 structure will enable the hospital to house more than 600 patients.

Because of a shortage of nurses, it has been decided that a 13-bed section of Victoria Public Hospital, Fredericton, will be closed.

Auxiliaries

(concluded from page 64)

by a trained nurse while she is on duty. Members then show the photos to the proud parents, take their order, and collect the money when the prints are delivered. The brand new mama and daddy are happy with the pictures, and at the same time the young patients in the hospital benefit through the funds raised. A worthy project, indeed!

Faithful Service

Since 1929, St. Joseph's Hospital in Saint John, N.B., has boasted an organized women's auxiliary. Every year, the ladies provide financial assistance and equipment, valued between $1,500 and $2,000. This year, a Maytime tea in the out-patient department helped the auxiliary towards its goal. Among the many articles supplied to the hospital, stands a very impressive Hammond electric organ, installed in the chapel.

Montreal Course

(concluded from page 62)

Les cours sont donnés sous la direction du Gerald LaSalle, M.D., D.H.A. (Toronto), et de Mère Jeanne-Mance, r.h.s.j., D.H.A. (Toronto). On est prié de s'addresser à l'Institut Supérieur d'Administration Hospitalière, pour plus amples renseignements.

Blue Cross Calls up its Reserves

According to a release issued by the Blue Cross Commission of the American Hospital Association in Chicago, Ill., Blue Cross Plans in the States had to dip into reserve funds for the first time during 1957. More than eight million dollars had to come from reserves to meet the cost of services and benefits guaranteed by the members' contracts. On a national average, the total represents more than one-half cent paid out by plans over and above each dollar paid by subscribers to the plan.

Last year also saw hospital admissions increase as well as the average number of days of hospitalization, and the cost of hospital care. In short, more Blue Cross members were hospital patients during 1957 than ever before. More than two million new members were added, bringing total membership to 55,940,416 in the United States.

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Pre-wrapped individual 12″ KOTEX. Use bag for discarding pad.

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- less nursing time—greater economy
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News Released by Hospital Supply Houses

By C.A.E.

T. B. James 90 Years Old

Mr. and Mrs. T. B. James.

On Sunday, July 20, T. B. James, president and general manager of the J. F. Hartz Company Limited, celebrated his 90th birthday. Mr. James founded the J. F. Hartz Company on January 1, 1900 in the old Confederation Life building on Yonge Street in Toronto. He has served continuously as president and general manager since that time and still plays an active rôle in the company. Mr. James graduated in 1891 from the Ontario College of Pharmacy and is one of the oldest, practising pharmacists in Ontario. To celebrate the occasion Mr. and Mrs. James were honoured at a party given by the employees of the Hartz Company.

The Norfield "Summarizer" Speeds And Simplifies Figure Work

The Norfield "Summarizer" has just been introduced to give a new and effective means of handling the summarizing and assessment of figures. It can be used for any problem where returns must be summarized, and, what is important, without the use of any machine other than a standard adding machine.

The benefits of the Norfield "Summarizer" method of handling statistics spring from two main facts. Firstly, all summarized figures can be obtained from the original forms themselves, and secondly, these forms are handled on the Norfield "Summarizer" with a speed and accuracy otherwise unattainable.

Previously the summarizing of analyzed figures has meant either expensive processing machine equipment, or copying the manual of details from the original forms into a summary book. A calculating-machine operator has thumbed through a pile of forms time and time again to build up totals. The Norfield "Summarizer" method offers practical advantage over these and other methods.

Since only the original forms themselves are used, the laborious transcription of figures is entirely eliminated. This not only saves hours of clerical time, it means also that copying errors simply cannot occur. It is unnecessary for an operator repeatedly to go through stacked forms to pick up totals, with the constant risk of picking up a wrong figure.

The Canadian agents for this equipment are: R. S. Hart & Company Limited, Systems Division, 489 King Street West, Toronto.

Arborite Panels For The "Do-it-yourself" Man

A new product, which is of interest to the "Do-It-Yourself" workman, has been introduced by The Arborite Company Limited.

Genuine Arborite "Handi-panel" is a one-size panel 18″ x 48″ and is 1/16″ thick. This makes it ideal for covering tables, phone tables, window sills, small shelves, dresser tops, and for push and kick plates for doors. Two popular, well-blending patterns are being featured—sliced walnut and tan modern oak. Each panel is sealed in polythene for protection and comes complete with "How to Apply" instructions.

Introduction of the new product coincides with the 10th anniversary of the Ville La Salle plant of the Company, now one of the largest manufacturers of plastic laminates in Canada.

New Minute Volume Meter

A new minute volume meter has recently been designed by Ohio Chemical and Surgical Equipment Co. to eliminate guesswork and give a direct reading to the patient's average minute volume. In respiratory studies not associated with anaesthesia the minute volume meter will assist in diagnosis.

In the application of the minute volume meter during surgery, the patient's normal minute volume can be checked prior to the operation or determined from data on the Radford Chart. After the patient has been anaesthetized and during the surgical procedure, only a glance at the indicator is necessary to determine if the minute volume is normal. For more details please request Bulletin 4802 from Ohio Chemical Canada Limited, 180 Duke Street, Toronto, Ontario.

(continued on page 106)

New Sterilizer for Containers and Utensils

The Vacuum Can Company, Chicago, Illinois, have introduced a new stainless steel sterilizer for refuse cans, mixing kettles, stock pots, milk cans, large kitchen utensils, and insulated containers of any shape with diameter up to 25" which need cleaning and sterilizing to maintain sanitary conditions. According to the company, the sterilizer performs five labour saving functions—washing, rinsing, sterilizing, de-odorizing and pre-heating—by simple easy movements of the foot pedals. It operates with either low or high boiler pressures, using cold water, hot water and steam in any combination or sequence.

The unit is made up of a large seamless bowl, with sanitary self-rinsing contour mounted on adjustable legs. Swivel ball point feet permit leveling and cleaning of all under surfaces. Elevated in the centre of the bowl (to prevent back siphoning) is the revolutionary new cyclonic-whirling spray nozzle which propels powerful jet sprays in a 210° arc and washes every minute area with a centrifugal scouring action. The bowl also has spokes to elevate a container and a drain with a large sediment cup and screen. For further information write to Vacuum Can Company, 19 S. Hoyne Avenue, Chicago 12, Illinois.

Canadian Liquid Air Appointments

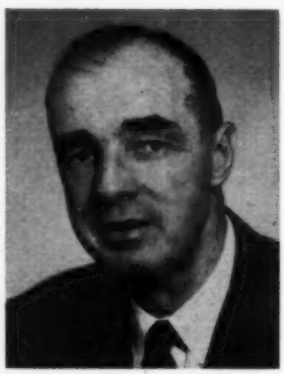
Canadian Liquid Air Company Limited has announced the appointment of Gordon V. Tristram as supervisor of the Medical Gas Division at its head office, Montreal. Born and educated in Winnipeg he was formerly medical gas supervisor at the company's Toronto branch office.

As a specialist in oxygen and anaesthetic equipment and their applications, Mr. Tristram is well known throughout the medical profession and his wide experience in the hospital technical service field covers both Canada and the United States.

George Heggie, formerly cylinder control representative for Canadian Liquid Air Company in Montreal, has been appointed medical gas representative in the Toronto office. Mr. Heggie joined Liquid Air in 1947 at Winnipeg and has also served the company in various capacities in Edmonton, Calgary and Montreal.

General Manager of Gordon A. MacEachern Limited

The appointment of Gordon D. Hay as executive vice-president and general manager has been announced by Gordon A. MacEachern, president of Gordon A. MacEachern Limited, floor-finishing specialists.



Gordon D. Hay.

Mr. Hay was born and educated in Montreal and has spent the past 21 years in Toronto as manager of West Disinfecting Co. Limited. He is well known in the floor-finishing and sanitation products industry throughout Canada. He lives in Etobicoke Township.

New Micro-Filter for the Isolette

The Micro-Filter, a new, highly efficient but simple air filter, is now available through Air-Shields (Canada), Ltd., for use on their Isolette (R) infant incubator to remove contaminants from hospital nursery air, and help minimize the danger of air-borne infections in the premature nursery.

The Isolette incubator has a unique system of forced circulation of air from outside the hospital thus providing protection from air-borne bacteria and complete isolation for the baby. No nursery air enters, since there is always a slight flow of air outward from the Isolette. Now the Isolette, when equipped with the new Micro-Filter provides complete isolation even when not connected to an outside air source.

Laboratory studies of the Air-Shields Micro-Filter have shown an efficiency of 99.50 per cent in removing particles varying in size from 0.5 micron to 3.4 micron with a mass median diameter of 1.7 micron. The average diameter of the pathogenic staphylococcus is 0.8 micron, and the bacterium most frequently found in irregular grape-like clusters, staphyloccocci are efficiency removed from hospital nursery air by the new Micro-Filter.

The Micro-Filter assembly consists of a polished, cast aluminum filter body, clear plastic cover, oxygen input nipple, all necessary fasteners for installation on any Isolette incubator and one dozen fibrous Micro-Filter pads—approximately one year's supply.

Write for information to Air-Shields (Canada), Ltd., 8 Ripley Avenue, Toronto 3, Ontario.

Singer "Nursesaver" Hospital Bed

A new "electromatic" high-low hospital bed has been introduced. Known as the Singer Nursesaver it features modern styling and engineering. It is mounted on 5" swivel wheels for easy handling and comes equipped with a Gatch spring and Singer "Comfort-plus" mattress.

(concluded on page 108)

Across the Desk

(concluded from page 106)

The high-low mechanism is push-button operated and consists of only six moving parts that are all pivoted on ball-bearings and lubricated for life. The mechanism is activated by two Acme screws, which require greasing twice yearly, mounted on bearings. Head and foot raising mechanisms are pivoted on Oilite bushings and, according to the company, give easy fluid operation and silent performance. The completely enclosed motor is lubricated for life and is said to be quiet and free from vibrations.

Attached to the Singer high-low bed is a collapsible overbed table which can be maneuvered by the patient. For a descriptive folder on this bed write to Ideal Upholstering Co. Limited, 299 Marien Avenue, Montreal East. Quebec.

New Linde Air President

The appointment of Whitford S. Wyman as President of the Linde Air Products Company, Division of Union Carbide Canada Limited has been announced by A. A. Cumming, president, Union Carbide Canada Limited.

Whitford S. Wyman

Mr. Wyman joined the Linde organization 30 years ago, following his graduation in mechanical engineering from Cornell University. He has held various positions in research, development, and plant supervision. Since 1956, Mr. Wyman has been vice-president and general manager.

Two-Way Chart File System

The Shampaine-Boone two way chart file system is designed to promote efficiency in departmental organization and administration. Perfected by the Shampaine Company of St. Louis, Mo., it is adaptable to a large or small hospital operation and eliminates confusion through placement of charts in especially allocated sections of the rack.

Four persons, two on each side, can work simultaneously and without interference. Chart identification strips are placed at both ends of the holders. Self centering charts are always within arm's reach. Units are available in both 40 and 30 chart capacity.

A transparent plastic pocket designed to hold the admission slip is attached inside the chart holder. This allows instant scanning of information about the patient.

The Shampaine-Boone chart file is constructed of heavy guage furniture steel and finished in baked enamel. An alumilited aluminum trim adds to the appearance and strength of this unit.

Literature Available on Ultrasonic Cleaner

The new high-speed Castle Ultrasonic Cleaner is described in Bulletin H246, now available from Wilmot Castle Company, manufacturers of lighting and sterilizing equipment for hospital, medical and dental applications.

The new unit sends high frequency sound waves through a detergent to remove grease, dried blood and other soils from the surface of instruments, glassware and small utensils. In tests "frozen" syringes have been freed and even "permanently" stained instruments have come clean. A full load of 75 to 100 instruments, which would take almost one hour to wash manually, can be completely cleaned in 6 or 7 minutes with this new cleaner. The equipment is fully automatic. One turn of the timer fills the unit to proper level, washes, drains, rinses and shuts off. No residues are left to "settle out" on instruments and every trace of soil is evacuated before removal of tank contents.

The new bulletin describes the complete line of compact individual cleaners and dryers, large all-purpose combination cleaner-dryers and inexpensive laboratory portables. Copies may be obtained by writing: Advertising Manager, Wilmot Castle Company, 1920 East Henrietta Road, Rochester, New York.

Sigmol "Sodium-Free" Disposable Enema

A new disposable enema, called "Sigmol" containing no sodium, has been made available to Canadian hospitals by Pharmaseal Laboratories, Glendale 1, California. Since there is no sodium in its formula, it can be given to any patient capable of taking an enema, including those on low sodium or sodium-free diets. The formulation is basically Sorbitol, a sugar alcohol solution, but also contains a fecal softener in the form of dioctyl potassium solfosuccinate. Sigmol is a non-toxic, non-conducting and non-irritating hypertonic solution which activates and relieves the patient within minutes. Hazards frequently associated with giving other types of enemas; namely, irritation and distention of the bowel from excessive fluid volume, are nonexistent. Sigmol is sold in disposable plastic packages containing 4¼ fluid ounces of solution which will not irritate sensitive or damaged rectal membranes. Furthermore, a superior detergent action cleans rectal mucosa thoroughly, giving a desirable advantage for clear sigmoidoscope examination. Additional information can be obtained from A. J. Siposs, Canadian territory manager, 15 Cliffside Drive, Toronto, Ont.

Brochure on Diesels

A 12-page illustrated brochure entitled "There is a difference in Diesels", has just been released by General Motors Diesel Limited, London, Ontario. Copies of the brochure may be obtained from General Motors Diesel distributors or dealers, or by writing to General Motors Diesel Ltd., London, Ont.

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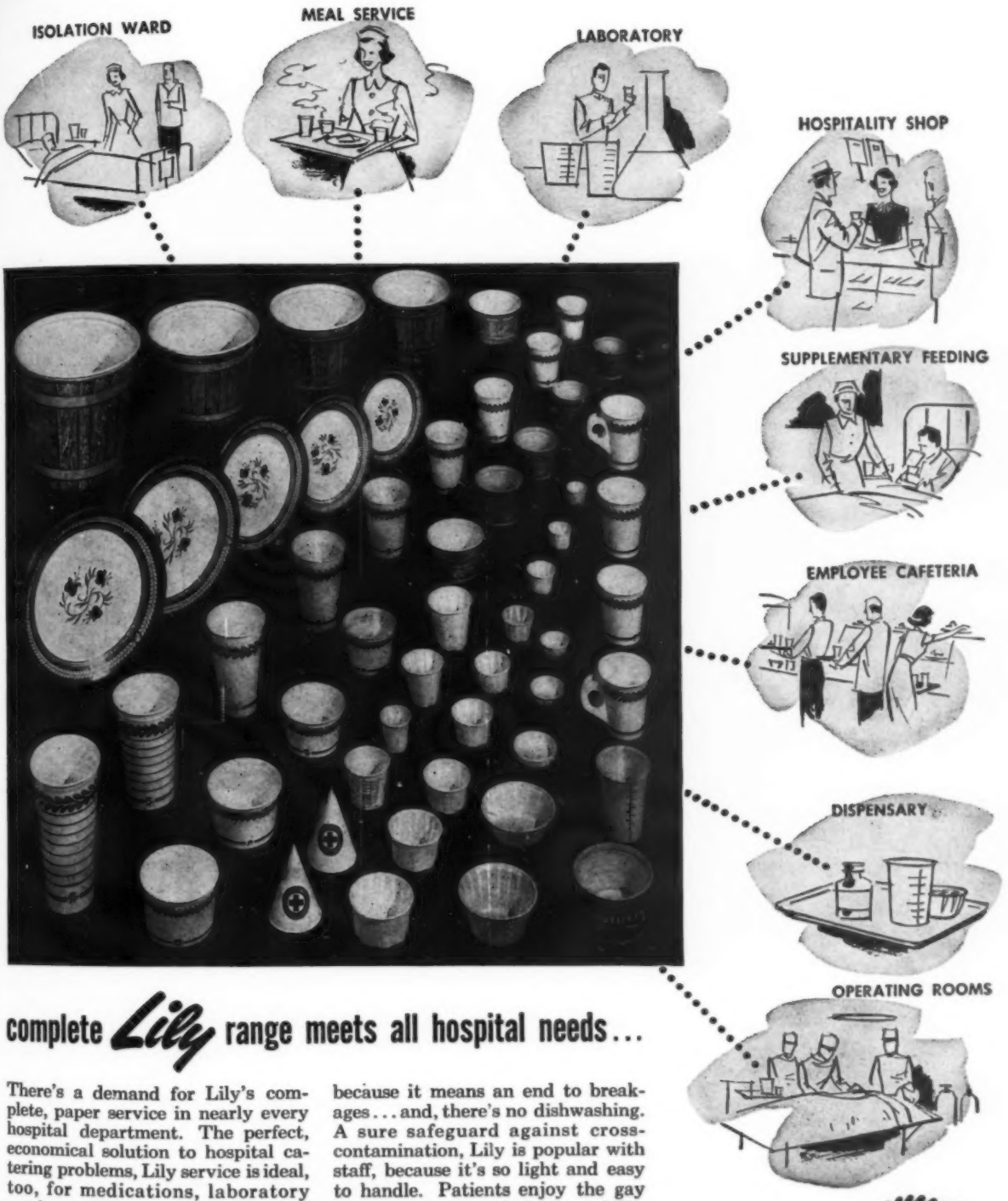

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